CONSENT TO TREATMENT

The policies and practices of Link Psychiatry are described in the document, "Office Policies and Practices." You have been given a copy of "Office Policies and Practices" for review. The purpose of this form is:

1. for you to give your consent, in writing, to receive services from Link Psychiatry, Inc.; or
2. if you are consenting on behalf of your child, for you to give your consent, in writing, for your child to receive services from Link Psychiatry, Inc.

Please initial next to each statement indicating your agreement with the statement. Please only initial next to the statements with which you agree.

"My decision to seek services from Link Psychiatry is voluntary. I have read the document entitled, "Office Policies and Practices," and I understand the policies and procedures detailed in it. I agree to adhere to the policies and procedures detailed in this document and I consent receive services from Link Psychiatry." _____

"I understand that psychotherapy involves both risks and benefits. Risks include experiencing painful anxiety, emotions, cognitions, memories, and impulses. Although there is an expectation that psychotherapy will be beneficial, there is no guarantee of benefit. Possible benefits include lower anxiety, less behavioral impairment, clearer cognitions, and improved emotional closeness with others. I understand these risks and benefits and I consent to psychotherapy from Link Psychiatry." _____

"I understand that Dr. Link regularly receives professional consultation with regard to patient care. I consent to have Dr. Link disclose my private information to consultants and colleagues for the purpose of professional consultation." _____

"I understand that Dr. Link regularly creates audio and/or video recordings of psychotherapy sessions for the purpose of quality improvement. I consent to have Dr. Link create, maintain, and listen to or watch audio and video recordings of my psychotherapy sessions for the purpose of quality improvement." _____

"I consent to have Dr. Link show audio and video recordings of my psychotherapy sessions to consultants, supervisors, and colleagues for the purpose of professional consultation and supervision." _____

Please sign below to indicate that you agree with all statements that you have initialed above and that you consent to receive services from Link Psychiatry, Inc.

Signature _____ Date _____