## CONSENTS AND NOTIFICATIONS

**CONSENT FOR TREATMENT**

I consent to the evaluation and treatment process with Edgewood and I understand that this process may include myself, spouse, children, and/or other family members. I understand that I have the right to withdraw from treatment at any time. I understand that if my child is the client, the child's other legal or biological parent or guardian may be informed of our child's treatment. I understand that the number of visits I receive will depend on the type(s) of issues that exist, the recommendations made, and the effort that I put forth by following suggested recommendations. Initials _____

**ELECTRONIC COMMUNICATION**

I consent to sending and receiving email communications with Edgewood. I understand electronic communication is not encrypted and third parties may have access to my email. I assume responsibility for any compromised communication. Initials _____

**NEWSLETTER COMMUNICATION**

I consent to receive Edgewood newsletters and service update and opportunities notifications via email. Initials _____

**TELEPHONE COMMUNICATION**

I consent to receiving telephone communications with my clinician about treatment. Initials _____

**CONSENT FOR SMS TEXT NOTIFICATIONS**

I consent to receive appointment reminder SMS texts from 847.973.5686. I understand that I must contact Billing@EdgewoodServices.com to discontinue this notification and that normal cell charges will apply. Initials _____

**CONFIDENTIALITY**

I understand that all clinical information is kept strictly confidential and will not be released without my written authorization except in the cases of suspected child abuse, child neglect, lethal danger towards self or others or treatment and payment operations as required under Illinois state law. Further, I have protected health information rights to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I received a summary of the Notice of Privacy Practices and understand a complete notice of patient rights and grievance policy may be obtained at EdgewoodServices.com. Initials _____

**CRISIS/EMERGENCY NEEDS**

I understand that Edgewood **DOES NOT** provide crisis/emergency services. I must call 911, go to the nearest emergency room, or visit Linden Oaks Naperville if I need immediate attention. Initials _____

**My signature reflects my understanding and acknowledgement of the above initialed consents and notifications.**

| ______________________ | ______________________ | __________ |
|---|---|---|
| Client Signature (12 & over) | Client Printed Name (12 & over) | Date |
| ______________________ | ______________________ | __________ |
| Parent/Guardian Signature (under 12) | Parent/Guardian Printed Name (under 12) | Date |

## CONSENT TO RELEASE INFORMATION TO OTHER MEDICAL PROFESSIONALS

By signing below, I am electing to share relevant treatment information with a Primary Care Physician or other Health Care Provider to support coordination of my health care needs. _____ I refuse permission to share my treatment information.

| PROVIDER NAME | PROVIDER ADDRESS | |
|---|---|---|
| PROVIDER PHONE NUMBER | EMAIL | PROVIDER SPECIALTY |

| ______________________ | ______________________ | __________ |
|---|---|---|
| Client Signature (12 & over) | Client Printed Name (12 & over) | Date |
| ______________________ | ______________________ | __________ |
| Parent/Guardian Signature (under 18) | Parent/Guardian Printed Name (under 18) | Date |