Spectrum Psychological Associates, Inc.
Consent to Treat

I, _____
(**Print the patient's full name on the line**) authorize providers of the Spectrum Psychological Associates, Inc. (Spectrum) to treat me for my health, wellness and routine care management. I authorize Spectrum providers and their designees to perform routine examinations, order or perform diagnostic or routine procedures pertaining to my care and to counsel me, and to allow communication about my health, wellness and routine care management. I acknowledge that no guarantee or assurance has been made to me regarding the result of any examination or treatment.

In the event of a medical emergency, I authorize Spectrum to provide necessary emergency care and transport to me to an affiliating hospital for care, if necessary.

When we examine, diagnose, treat or refer you, we will be collecting what the law calls Protected Health Information (PHI). We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need to arrange payment for your treatment, or for other business or government functions. THE NOTICE OF PRIVACY PRACTICES (NOPP) EXPLAINS IN MORE DETAIL ABOUT YOUR RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), AND HOW SPECTRUM CAN USE AND SHARE YOUR PHI. PLEASE READ THE NOPP BEFORE YOU SIGN THIS AGREEMENT. In the future, Spectrum may change how your information is used and shared, and so Spectrum's NOPP may change. If we do change our NOPP, you can get a copy by calling us at (440) 446-9696, or from our Privacy Officer.

After you have signed this Consent to Treat Form, you have the right to revoke it (by writing a letter telling us that you no longer consent) and we will comply with your wishes regarding treatment from that point forward.

I HAVE READ THIS ENTIRE FORM AND I UNDERSTAND ITS CONTENT. I HAVE HAD THE OPPORTUNITIY TO ASK QUESTIONS ABOUT THIS FORM AND I HAVE HAD THE QUESTIONS THAT I DID ASK SATISFACTORILY ANSWERED. I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES (NOPP) FOR SPECTRUM PSYCHOLOGICAL ASSOCIATES, INC.

_____/_____/_____ _____
Date **Patient's Signature**

OR
_____/_____/_____ _____
Date **Parent or Legal Guardian's Signature (if applicable)**

NAME OF EMERGENCY CONTACT: _____
List all appropriate phone numbers for your emergency contact:
Work (__ __ __) __ __ __ - __ __ __ __
Home (__ __ __) __ __ __ - __ __ __ __
Cell (__ __ __) __ __ __ - __ __ __ __
Other (__ __ __) __ __ __ - __ __ __ __

Relationship of Emergency Contact to Patient: spouse, child, sibling, parent, friend or if other, please list relationship: _____

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