EMERALD
Psychiatry & TMS Center

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that I am eligible to receive services from Emerald Psychiatry & TMS Center. The services I receive will be through initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared with the clinical staff at Emerald Psychiatry & TMS Center is confidential and no information will be released without my written consent. I further understand that there are specific and limited exceptions to this confidentially which include and are not limited to the following:

- If I am a danger to myself or someone else, the clinician is ethically bound to take necessary steps to prevent such danger.
- If there is suspicion that a client is being abused or neglected, the clinician is legally required to take steps to protect the client and inform the proper authorities.
- When a court order is issued, the clinician and the office are bound by law to comply with the request.

I authorize Emerald Psychiatry & TMS Center to bill my insurance and release pertinent information to my insurance carrier. I understand that I am liable for all co-pays, deductibles and any fees unpaid by insurance. I understand that payment for all fees are due at the time of service.

If I have any questions regarding this consent form or about the services offered at Emerald Psychiatry, I may discuss them with the staff. I understand that I may stop treatment at any time. I consent in the evaluation and treatment offered to me by Emerald Psychiatry & TMS Center and I have read and understand the above.

_____	_____
Print Name	Date of Birth
_____	_____
Signature	Date
_____	_____
Guardian Signature (if applicable)	Date