

**CONSENT TO TREATMENT** *(For Outpatient Services)*

By signing this form, I give Easterseals Capital Region & Eastern Connecticut (“Easterseals”) permission to provide evaluation and/or treatment services for me or the person I am legally authorized to represent.

**Consent for Treatment and Services**

- I authorize Easterseals to provide necessary evaluation, treatment, and coordination of care.
- **Participation in treatment is voluntary** and may be stopped at any time by notifying Easterseals in writing.
- Treatment may involve discussing personal or difficult topics, which may be temporarily uncomfortable.
- For minors, parent/guardian involvement in sessions will be discussed with the family and determined based on the treatment plan.
- I am **responsible for attending scheduled appointments**. Missed or late-cancelled appointments may result in a fee or discharge from services, as outlined in the Financial Agreement.
- My health information will be protected according to HIPAA regulations.
- Recording of any session (in-person or telehealth) is **not permitted** without prior written consent.
- Easterseals is a training site and trainees may observe or assist under supervision. I may decline their involvement at any time.
- In an emergency, Easterseals may contact emergency services and authorize necessary treatment, including hospital transport. Easterseals staff cannot follow Do Not Resuscitate (DNR) orders.

**Telehealth Acknowledgement**

- Telehealth (video or phone) may be used when appropriate. Either I or my provider may request to switch to in-person sessions if needed for clinical or safety reasons
- I am responsible for my internet connection, device, and privacy at my location. I will confirm whether my insurance covers telehealth or if I will need to pay out of pocket.
- I agree to state my physical location at the start of each session.
- If there is a safety concern or emergency during a session, my provider may contact emergency services or my emergency contact.
- Technical issues may disrupt sessions; I agree to reschedule if needed.

**Consent for Psychological and Neuropsychological Testing (if applicable)**

- Testing may assess thinking, learning, memory, attention, emotions, or behavior and may occur across multiple visits. There is **no guarantee of specific diagnoses or recommendations**.
- Testing is for clinical diagnosis and treatment planning only. It is not for legal purposes (e.g., disability, custody, or court) and does not establish an ongoing treatment relationship.
- Billing includes scoring, interpretation, and report writing completed outside of appointments and may take several days or weeks. Time billed is **based on work performed, not on specific test results**.

**Privacy Practices and Information Sharing**

- I have received and reviewed the Notice of Privacy Practices.
- Information shared in treatment is confidential **except when required by law** (such as safety concerns or a court order).
- In group services, confidentiality is shared among participants and I agree to respect others’ privacy.
- I authorize Easterseals to share necessary information with my insurance for billing and with my referring provider for care coordination. I may request additional disclosures or limits in writing.
- HIPAA-compliant tools, including AI-assisted systems, may assist documentation under provider review. These tools are used only within secure systems and do not replace provider review.
- I have the right to receive information about my treatment, ask questions, and request a change of provider.

**Consent for Treatment: To be signed by the patient or their legal representative**

- **By signing, I confirm I have read this form, had the chance to ask questions, and voluntarily consent to treatment.**
- If I am signing for a minor or dependent adult, **I confirm that I have the legal authority to consent to treatment** for them.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Relationship to Patient:  Self  Parent  Guardian  Conservator of Estate  Other