p 410.863.7213 f 410.987.3154 www.pdgrehab.com
1110 Benfield Blvd, Suite B, Millersville, MD 21108

INFORMED CONSENT FOR TREATMENT

I hereby give my permission and consent to receive treatment from PDG Therapeutics. I understand that this encompasses the intake and diagnostic evaluation process, as well as any therapies and/or referrals which may be recommended.

I acknowledge that the "Client's Rights" and "Grievance Procedure" statements have been provided to me. I have had an opportunity to review it and to ask any question which I may have about my rights as a client of PDG Therapeutics. "Client's Rights" and "Grievance Procedure" are posted on our website at www.pdgrehab.com, as well as in our lobby, and can be accessed or printed at any time.

I understand that all my treatment at PDG Therapeutics is voluntary, and that I may cease treatment at any time by informing my therapist and/or the office staff.

I understand that my clinical records and any verbal or written communications between myself, my parent (if applicable), or any authorized representative are strictly confidential. Further, no material or information will be disclosed to another party without my express written consent and/or that of a legally authorized representative. This excludes circumstances when there is a clear and imminent danger to myself or to others, or when disclosure is state-mandated (reported sexual abuse, physical abuse or neglect as a child or suspected current child abuse).

I understand and give my informed consent to PDG Therapeutics staff and or clinicians to contact police, emergency contacts and or emergency services if there is a medical emergency.

I hereby request PDG Therapeutics and its qualified members to call for other related support services as deemed necessary and appropriate for my emotional and physical safety.

This informed Consent has been explained to me, and I have been offered a copy for my records.

X _____
Printed Name

X_____
Client Signature **Date**

_____
Therapist/Intake Worker **Date**