*CONSENT FOR CARE AND TREATMENT*

I agree and consent to participate in the mental and behavioral health services offered by Dr. Zorica Filipovic-Jewell. My right as a patient, is to be informed about my condition and the recommended course of treatment. This is important, so that I have enough information to make the decision whether or not to undergo treatment after knowing the risks involved.

Although at this point in my care, no specific treatment plan has been recommended, this consent form is simply to obtain my permission to perform the necessary evaluation and to identify the most appropriate treatment course. Therefore, this consent provides Dr. Zorica Filipovic-Jewell my permission to perform the reasonable and necessary assessment, evaluation, examination and testing including laboratory and drug toxicology testing.

By signing below, I am indicating that:

1. I have reviewed a copy of Dr. Zorica FIlipovic-Jewell’s privacy policy, practice policies and procedures and the HIPAA notice form

2. I am agreeing only to those services that Dr. Zorica FIlipovic-Jewell is qualified to provide within the scope of her license, certification and training

3. I am consenting to receiving treatment at this office

4. This consent is continuing in nature even after the initial diagnosis and treatment recommendation has been made

5. The consent will remain fully effective until it is annulled in writing

6. I have the right to discontinue care with Dr. Zorica FIlipovic-Jewell at any time.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient of Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness’ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*CONSENT TO CORRESPOND ELECTRONICALLY*

While Dr. Zorica Filipovic-Jewell takes reasonable precautions to protect my confidential information, I understand that e-mail and other sources of electronic communications are not completely secure methods of communication. I understand that in most circumstances, electronic communication is not a way of communicating new information regarding care or of communicating emergency needs. I further understand that I must speak to my clinician directly regarding all important information pertaining to my treatment. Although my clinician will attempt to reply in a timely fashion, I further understand that if I am experiencing an emergency situation and need to contact someone immediately to help me, then I will call 911 or the nearest emergency room. I grant Dr. Zorica Filipovic-Jewell permission to communicate with me via e-mail. I acknowledge that if I use e-mail to initiate contact with my clinician regarding my care, the clinician has my permission to correspond via email address or other forms of electronic communications.

Name of Patient or Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient of Personal Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_