GLOBAL HEALTHCARE SERVICES, LLC.
Joint Commission Accredited

CONSENT FOR TREATMENT FOR OMHC, ASSESSMENTS, PRP, MEDICATION MANAGEMENT, GROUP THERRAPY & INDIVIDUAL THERAPY

I, _____ (Client's name) agree to participate in treatment with and through Global Healthcare Services. I understand that this treatment will be for my mental health and physical welfare. I understand that I have the right to have any medication or prescription recommendations explained to me in full and that I have the right to review medications with my psychiatrist or Psychiatric Mental Health Nurse Practitioner (PMHNP/ Representative.

I understand that I have the right to ethical and fair treatment given without regard to my race, religion, ethnic origin, sexual orientation or color. I understand that I have the right to appeal any decision made in my treatment by first discussing it with my primary treating professional. I understand that if I am not satisfied with the determination of this appeal, I may appeal to the Medical Director and the Program Director. I understand that I may refuse treatment with 48 hours' notice. I understand that if I choose to refuse treatment or to rescind this agreement for treatment with Global Healthcare Services against medical advice, I will hold Global Healthcare Services blameless and harmless for any pain or suffering I may incur as a result of that refusal or cessation of treatment. I have been given a copy of Client Rights, Grievance Process, and Maryland Notice Form for my review.

I understand that I may be discharged from Global Healthcare Services under the following conditions:

1. Successful completion of treatment goals
2. Failure to keep regular appointments or failure to attend sessions for a 90-day Period
3. Decision regarding different choice of treatment
4. Refusal to follow agreed-upon goals
5. Persistent AWOL behavior
6. Disrespectful behavior
7. Violent and/or criminal activities.

I give Global Healthcare Services and their representative coassignee permission to share any information necessary with any insurance company to obtain payment for medical services to me.

Client Signature: _____ Date: _____

Patient's/Guardian Signature: _____ Date: _____