Informed Consent for Assessment & Treatment

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Name: ____ Date of Birth: ___/___/___

I understand that as a patient of Dr. Karen Horst, I may receive a range of mental health and wellness services. The type and extent of services that I will receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me.

I understand that after the initial assessment it may be determined that Dr. Horst is not the appropriate clinician for me, and if so, this will be communicated to me directly.

I understand that all information shared with Dr. Horst is confidential and no information will be released without my consent. During the course of treatment it may be necessary for Dr. Horst to communicate with other clinicians. Consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, Dr. Horst is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, Dr. Horst is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, Dr. Horst is bound by law to comply with such requests.

I understand that while psychotherapy and/or medication may provide significant benefits, they may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications or supplements may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered, I may discuss them with Dr. Horst. I have read and understand the above. I consent to participate in the evaluation and treatment offered.

Signature: ____ Today's Date: ___/___/___