Patient Rights and Consent to Evaluate/Treat

The therapists at ABG Therapy and Wellness Center LLC are professionals who are ethically and legally responsible for keeping all information gathered in the evaluation or treatment process confidential. Your permission is required to release any information to any other person, except in cases of imminent danger, neglect, or abuse as is required by law. You have the right to seek a second opinion or to end the evaluation/treatment at any time. You are entitled to information about the methods and techniques used in the evaluation/treatment, an estimate of the duration of the therapy, and the cost to you and your family. You may also ask your therapist for information about his/her training and credentials. In any professional relationship, sexual intimacy is not appropriate and should be reported to a Professional Grievance Board. There are state regulatory agencies, which govern the practice of licensed and unlicensed therapists in the State of Colorado. You have the right to contact these agencies or the appropriate Grievance Board if you have questions or complaints about the services you receive. The Grievance Board for therapists can be reached at 1525 Sherman Street, Denver, CO. 80203; phone number (303) 866-3248.

I VERIFY THAT I HAVE READ AND UNDERSTAND THE INFORMATION PROVIDED TO ME ABOUT MY RIGHTS AND THE EVALUATION OR THERAPY TO BE COMPLETED. I GIVE MY PERMISSION FOR TREATMENT BY ABG THERAPY & WELLNESS CENTER LLC THERAPISTS. I UNDERSTAND THAT NO GUARANTEE CAN BE MADE TO ME REGARDING THE RESULTS OF THE EVALUATION AND/OR TREATMENT, AND WILL NOT HOLD THE THERAPIST LIABLE FOR THESE RESULTS.

I FURTHER ACKNOWLEDGE THAT MY THERAPIST WILL CHARGE THE APPROPRIATE AGENCY, INSURANCE COMPANY OR RESPONSIBLE PARTY FOR THE SERVICES RENDERED. I ALSO UNDERSTAND THAT, WITH THE EXCEPTIONS OF MEDICAID CLIENTS, SHOULD THE PARTY THAT IS BILLED FOR SERVICES REFUSE TO PAY, I WILL BE RESPONSIBLE FOR ALL COSTS FOR THE EVALUATION AND/OR TREATMENT NOT YET REIMBURSED TO MY THERAPIST. *(Please note that ABG will assist in any reasonable way to facilitate payment being made by the responsible agency, insurance company, or responsible party in a timely fashion.)*

I hereby consent and give permission for evaluation/treatment with therapists at ABG Therapy & Wellness Center LLC.

Client name: ____________________________ Client DOB ____________________________

Name of responsible party: ____________________ Relationship to Client ____________________

Signature of responsible party: ____

Date of signature: ____

I give permission for ABG Therapy & Wellness Center LLC to share reports and other pertinent information with the following:

Referring Physician________________________ (Required)