Greatland Mental Health, LLC dba,
Greatland Clinical Associates, LLC
1400 W. Benson Blvd. #315
Anchorage, AK 99503

Consent For Treatment

I hereby agree to treatment at Greatland Clinical Associates, LLC (GCA). (____init)

I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law. I understand that GCA and my clinician is required to report knowledge of current child abuse. I also understand that GCA and my clinician may be released from confidentiality statues if there is a serious intent to harm myself or others. I have read through and understand the Notice of Privacy Practices and Commitments and Expectations. (_____ init)

I understand that I need to give four (4) business days' notice on all prescription refills. (__init)

I understand that some clinicians use a scribe and/or have students observe sessions. I further know that I may decline the use of a scribe or student at any time. (____init)

I understand how to contact the clinic and have knowledge of the Crisis Line and clinic pager. (____ init)

If I am unable to keep an appointment, and do not give the office 24 hours advance notice my absence may be counted and charged as a session. (____init)

I give permission for GCA to contact me by the following contact means:

Phone: _____ Primary Phone for reminder calls.

TEXT: _____

Other Phone for Emergency use ONLY:_____

I have read, understand, and agree to the foregoing.

Printed Name

Signature **Date**