Maria Arcia, MD
Newton square health Center, PC
338 Highland Street
Worcester, MA

I _________________________ have chosen to receive treatment from DR. ARCIA at the Newton Square Health Center, PC. My choice is voluntary and I may terminate treatment at any time. I understand that I have basic rights as a patient that include:

1. The right to be informed of the various steps and activities involved with treatment.
2. The right to confidentiality under state and federal law.
3. The right to humane care and protection from abuse and neglect.
4. The right to make informed decisions whether to accept or refuse treatment.

I understand records will be kept of each visit and my records are protected under state and federal laws governing health care information that relates to mental health services and my records cannot be released without my consent unless otherwise provided for in state or federal regulations. I understand that I may revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in compliance of this consent and if I do not revoke this consent it will automatically expire one year after all claims for treatment have been provided in the benefit plan.

I understand that state and local law requires all cases of abuse or neglect of minor children or vulnerable adults will be reported. The law also requires all cases where there is a danger to self or others be reported to proper authorities.

I understand that in the event of an emergency Dr. Arcia or her coverage will make every attempt to respond to phone calls. I also understand that if I can't wait for a response I will go to the nearest emergency room. In Worcester that would be UMass Emergency mental health services at (508) 856-3562. I understand that if I call Dr. Arcia or her coverage and request a call I will completely unblock my phone. I understand that if I miss a scheduled appointment without 24 hours notice Dr. Arcia may charge me $50.00 per session.

Signature ____ **Date** _________________

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

I understand I may revoke this consent at any time to the extent action has been taken in reliance upon it and that in any event this consent shall expire one year from date of last visit unless another date is specified. I have read the above

( ) I give consent to release mental health/substance abuse information to my PCP

PCP Name ______________________________________ PCP Phone _________________

( ) I do not give consent to release my information tomy PCP

Signature ____ **Date** _________________

Signature ______________________________________ Date ____________________