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FAMILY MEDICINE | ADDICTION MEDICINE | MENTAL HEALTH
www.hhfamilymedicine.com

SAFETY CONTRACT

I, _____, agree not to attempt to harm myself or take my life during the course of my treatment under HHFM. In addition, if I feel strong suicidal impulses at any time, I will notify a support person (spouse, counselor, social worker, physician, ER) to receive help. Please note that as your medical provider, I cannot be responsible for your safety, other than requiring your signature on this form. We do provide 24/7 coverage for emergencies in addition to using emergency services "911" as a resource should you feel suicidal. If at any time you feel suicidal call our office and leave a message but ALSO call 911 or go to the nearest emergency room.

Signed

date

Witness