INFORMED CONSENT TO TREATMENT

Holistic Psychiatry
Comprehensive care for you

General Consent to Outpatient Treatment

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent to medical/mental health care and treatment, as ordered by a provider, while such medical care and treatment is provided through Holistic Psychiatry on an outpatient basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary. I agree and acknowledge that Holistic Psychiatry is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Holistic Psychiatry facilities.

Telemedicine

I understand that telemedicine (defined as the use of medical information exchanged from one site to another via electronic communications for the health of the patient, including consultative, diagnostic, and treatment services) may be employed to facilitate my medical/mental health care. All electronic transmission of data will be restricted to authorized recipients in compliance with the Federal Health Insurance Portability and Accountability Act (HIPPA) and applicable state privacy laws.

I understand that I am encouraged to exercise my right to discuss the treatment plan with my health care provider about the purpose, potential risks and benefits of any test ordered.

I hereby give my consent to receive medical care and/or treatment from the providers of Holistic Psychiatry at this office or any other satellite office under common ownership.

_____
Patient Name (Last, First)

_____ _____
Signature of Patient Date

If patient is unable sign or is a Minor under the legal age of 18 years:

_____ _____
Signature of Parent or Legal Guardian or Person Authorized to Sign Date

_____
Name of Parent or Legal Guardian or Person Authorized to Sign

_____
Relationship to Patient

The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

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Acknowledgement of Privacy Practices

Holistic Psychiatry provides information about how protected health information about me or the minor child or another person for whom I have authority to sign (the patient), including substance abuse treatment records protected under the Federal Regulations if any, and other mental health services including the communications made by me to a psychologist if any, may be used and disclosed. I have been offered an opportunity to review the Office Policies and Procedures Notice before signing this treatment consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the Holistic Psychiatry website at www.texasholisticpsychiatry.com or by contacting the Privacy Officer.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment, or healthcare operations.

By signing this form, I acknowledge that I have been offered and/or received the Holistic Psychiatry Notice of Privacy Practices.

_____
Patient Name (Last, First)

_____ _____
Signature of Patient Date

If patient is unable sign or is a Minor under the legal age of 18 years:

_____ _____
Signature of Parent or Legal Guardian or Person Authorized to Sign Date

_____
Name of Parent or Legal Guardian or Person Authorized to Sign

_____
Relationship to Patient