SPECTRUM MENTAL WELLNESS

OUTPATIENT CONSENT TO TREATMENT

I, the undersigned client, parent and/or legal guardian of _____ hereby gives my consent for and acknowledgement of the following items which are initialed:

_____ I consent to receive treatment. The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Spectrum Mental Wellness, LLC and its employed professionals. These services may include psychotherapy, medication based therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies

_____ I authorize Spectrum Mental Wellness, LLC., to release any information necessary for the completion of insurance forms for the determination of benefits payable by any insurance company, or any other institution/organization. A photocopy of this authorization shall be a valid as the original.

_____ I authorize Spectrum Mental Wellness, LLC to review my past pharmacy records through the secure Electronic Medical Record Dr. Crono. These records will be used to inform the clinician of past and current medications prescribed to ensure the safety of the patient.

_____ I have been informed of my providers credentials, licensure, experience, specializations, and limitations.

_____ I understand the possible psychological risks involved in psychotherapy and understand psychotherapy is not an exact science and that the results cannot be guaranteed. Psychotherapy is often beneficial, but as with any treatment, there are inherent risks. During therapy, I may have discussions about personal issues which may bring to the surface uncomfortable emotions such as anger, guilt, and sadness. Some of the possible benefits are improved interpersonal relationships, reduced feelings of emotional distress, resolution of problems resulting from past trauma, and increased problem solving skills.

_____ The risks, benefits, side-effects, and alternatives of treatment, as well as the consequences of noncompliance with treatment, have been discussed with me and I have had the opportunity to ask questions.

_____ I understand that I need to provide accurate information to my provider so that I will receive effective treatment. I also agree to play an active role in the treatment process.

_____ I understand that my provider may work with typists, internship students, supervisors, colleagues, legal entities, and case managers regarding my treatment and/or clinical files.

_____ I authorize Spectrum Mental Wellness, LLC., to relate my presence in this facility to specified callers and visitors, as documented on my releases in my clinical file.

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_____ I authorize Spectrum Mental Wellness, LLC. to contact me and/or my parent/guardian on my residence phone and/or my parent's/guardian's cell phone and/or my personal cell phone. I also authorize Spectrum Mental Wellness, LLC.to leave messages at any of the above phone numbers. Reminder emails, phone calls, and text messages will be sent to the email and phone numbers in the patient file unless otherwise directed in writing below.

_____ Please indicate which if any methods of communication for scheduling appointments or sending appointment reminders **are unacceptable** to you by checking the boxes below.

Cell Phone ☐ Text Message ☐ Email ☐

I have read and accept this agreement and herewith consent to therapeutic services provided by Spectrum Mental Wellness LLC.

_____ _____

Client signature Date

_____ _____

Parent or legal guardian signature Relationship to client