Consent to Treat

By signing below, I voluntarily consent to participate in mental health services provided by **Solara Psychological Services**, which may include but are not limited to: diagnostic assessments, psychological testing, psychotherapy, intake evaluations, treatment planning, and any adjunctive clinical services deemed appropriate by my provider(s). These services are intended to support psychological and emotional well-being and may involve discussion of personal history, sensitive topics, emotional experiences, and behavioral patterns.

I understand that participation in treatment may result in periods of emotional discomfort, and I agree to communicate openly with my provider(s) throughout the process.

I acknowledge that my provider will explain the nature, purpose, and expected course of any assessment or treatment procedures. I may ask questions at any time and understand that treatment is a collaborative process. I have the right to refuse or discontinue services at any point, except where otherwise required by law (e.g., in cases of court-ordered treatment, imminent risk, or mandated reporting).

All providers at Solara Psychological Services operate within the scope of their licensure or supervised practice and in accordance with applicable state and federal laws. If a clinician is under supervision, I understand this will be disclosed to me and the supervising clinician will be involved in my care as needed.

I consent to the exchange of information among treating clinicians within this practice when necessary for continuity of care. I understand that all information shared during treatment is confidential, with the following **exceptions** as required by law:

- If there is a risk of serious harm to myself or others,
- If there is suspected abuse or neglect of a child, elder, or vulnerable adult,
- If records are subpoenaed by a court of law or required by legal order,
- If disclosure is otherwise permitted or required by law.

If services are provided to a **minor**, I affirm that I am the legal parent or guardian authorized to consent to treatment on behalf of the child. I understand that while the provider may involve me in treatment planning, the minor may be entitled to privacy regarding certain matters as allowed under applicable laws and ethical guidelines.

(If applicable: I acknowledge that services may be delivered via **telehealth** platforms, and I understand the potential benefits, limitations, and risks associated with virtual care.)

I understand that Solara Psychological Services does not provide emergency services. In the event of a mental health emergency, I agree to contact 911, go to the nearest emergency room, or call a crisis hotline.

By signing this form, I acknowledge that I have read and understood this Consent to Treat and have had the opportunity to ask questions and receive answers regarding the nature and scope of services provided.

Name of Patient

Date

Signature

Relationship to Patient