Impact Psychiatric Care, LLC

Consent to Treatment

Patients must give voluntary consent for mental health treatment. Your signature (or that of your legal guardian) will demonstrate consent for receiving mental health treatment from Impact Psychiatric Care, LLC.

I voluntarily consent to mental health treatment as performed by Impact Psychiatric Care, LLC and its employees. This treatment may include assessment, screening, psychotherapy, injections, and psychiatric medication management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist.

I have read the above information and authorize Impact Psychiatric Care, LLC to provide mental health services to myself or this patient (if guardian).

Acknowledgment Agreement

Acknowledgement of Receipt of Impact Psychiatric Care's Consent to Treat Policy for Psychiatric Services

By signing this agreement, you agree that you have read the Impact Psychiatric Care's Policies, which contains information on our financial policy, professional fees, cancellation/no-show/late arrival, discharge policies, confidentiality, contacting your provider, electronic communications, reimbursement, and professional records, and you agree to abide by its terms during our professional relationship.

Acknowledgement of Receipt of Notice of Privacy Practices

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

Consent Form for Communication of Protected Health Information

I CONSENT to communication for appointment reminders via text, email, phone.

Cell phone number ______________________________ **Other contact number** ____________________________

Email Address____

I have carefully reviewed this document and agree to fully comply with the guidelines defined for the communication of my appointment reminders.

____________________________________	x____	______________
Please print patient's name here	Signature of patient/responsible party	Date

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Witness Signature

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

□ The patient refused to sign
□ Other (Please provide specific details): ____

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