SERENITY HILL
HEALTH CARE

Consent to Evaluate/Treat

Name (Printed): _____

Date of Birth: _____

1. **Consent:** I voluntarily consent that I will participate in a mental health (e.g., psychological, or psychiatric) evaluation and/or treatment by providers from Breakthrough Psychiatry LLC. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment

b. Alternative treatment modes and services

c. The manner in which treatment will be administered

d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).

e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a licensed psychiatric nurse practitioner. Treatment will be conducted within the boundaries of Colorado Law for Psychological, Psychiatric, Nursing, Social Work, or Professional Counseling.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered.

Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Breakthrough Psychiatry LLC, and I consent to disclosure for use by Breakthrough Psychiatry LLC providers for the purpose of continuity of my care. Per Colorado mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____

Signature of client Date

If you are under 15 years of age, your parents or legal guardian must sign below to verify that they have the legal right to authorize psychiatric treatment for you and understand the guidelines of confidentiality in treatment as outlined above.

Signature Parent/Legal Guardian: _____

Print name: _____

Relationship to Child _____

Signature: Parent/Legal Guardian: _____

Print name: _____

Relationship to Child _____

**NOTE: If I am unavailable and/or you are experiencing a medical or psychiatric emergency please call 911 or go to the nearest emergency department. Also available for mental health crisis: 1-844-493-TALK (8255), which is a 24/7/365 support line for anyone affected by a mental health, substance use or emotional crisis. All calls are connected to a mental health professional for support.