I affirm that I have read and understand the policy statements detailed in the document Regroup Counseling and Consulting PSC Informed Consent and am hereby requesting and consenting to mental health treatment including counseling and/or psychiatric medication management services.

I hereby request mental health services from Regroup Counseling and Consulting PSC and understand and agree to all practices as described in the aforementioned document. I understand that receipt of these services is fully voluntary and that I may withdraw this consent and terminate services at any time, for any reason.

If this consent is for a minor child in my care I agree that In my role as parent/guardian I will participate as an active member of the treatment team and will make myself available for consultation with the mental health provider as requested to ensure that treatment interventions are implemented in a timely fashion to ensure optimal treatment outcomes.

I have been given access to a copy or have received a copy of the Patient Bill of Rights which outlines the grievance procedure for Nurse Practitioners in the State of MN. I have read these rights and procedures and understand that staff will respect my right to seek clarification and will answer questions clearly and respectfully.

I understand that Regroup Counseling and Consulting PSC follows MN State requirement for checking and verifying in the Minnesota Prescription Drug Monitoring Program (PDMP) database for their patient:

- Before initially prescribing an opiate.
- Every three months for patients receiving an opiate for treatment of chronic pain or participating in medically assisted treatment (MAT) for an opioid addiction.

_____DATE_____

Signature of Client/Guardian

_____

Printed Name of Client