Abide Health Medical APC

6847 W. Charleston Blvd. Suite B
Las Vegas, NV 89117
Phone #: (725) 205-1578 Fax #: (725) 485-3749

Release of Liability Agreement

Effective Date: ___ / ___ / _____

Patient Name: _____
Date of Birth: ___ / ___ / _____
Address: _____

1. Acknowledgment of Risks

I, the undersigned, acknowledge that I am voluntarily seeking treatment, consultation, or participation in a service provided by **Abide Health Medical APC** (the "Provider"). I understand and acknowledge that certain risks are associated with the healthcare or behavioral health services I am receiving, including but not limited to:

- **Telehealth services** (if applicable), including risks of technical difficulties, confidentiality breaches, or miscommunications.
- **Mental health treatment**, which may involve emotional or psychological distress.
- **Physical health treatments**, which may involve discomfort, side effects, or other medical risks.
- The risks associated with **medication management**, which may include side effects or adverse reactions.
- **Therapeutic services**, including possible emotional reactions to the treatment process.

I acknowledge that while every effort will be made to minimize risks, these risks are inherent in the provision of healthcare services, and by signing this release, I accept these risks and agree to move forward with treatment.

2. Release of Liability

In consideration for receiving healthcare or behavioral health services, I hereby **release, waive, discharge, and covenant not to sue Abide Health Medical APC**, its employees, contractors, officers, and agents, from any and all liability, claims, demands, actions, or causes of action for personal injury, property damage, or wrongful death arising from or in any way related to the services I receive, whether caused by the ordinary negligence or conduct of the Provider or otherwise.

This release of liability applies to the following types of claims, unless prohibited by law:

- Claims related to the treatment provided (including medical and behavioral health services).
- Claims related to the outcome of treatment.
- Claims resulting from any inherent risks of treatment.
- Claims related to medication management and side effects.

I acknowledge that this Release of Liability is **not** intended to release the Provider from liability for acts of **gross negligence** or **willful misconduct**, as such actions are not permissible to waive under Nevada law.

3. Voluntary Agreement

I acknowledge that I am entering into this Release of Liability voluntarily and without coercion. I understand that this release is a binding agreement that limits my ability to bring legal action against the Provider in the future for certain types of claims, except those excluded under Nevada law.

4. Understanding and Consent

I certify that I have had the opportunity to ask questions regarding this Release of Liability and that all of my questions have been answered to my satisfaction. I fully understand the terms of this agreement and voluntarily consent to the healthcare or behavioral health services provided by **Abide Health Medical APC** under the conditions outlined in this form.

By signing below, I consent to treatment and acknowledge my understanding of the risks involved and the limitations of liability as described.

5. Emergency Contact Information

(If applicable, provide contact details for emergency purposes.)

- **Emergency Contact Name**: _____
- **Relationship**: _____
- **Phone Number**: _____

6. Consent to Treatment (if applicable)

I understand that this Release of Liability is being executed in conjunction with my **Consent for Treatment**, and I agree to abide by the terms of that agreement as well.

7. Patient Signature and Acknowledgment

By signing below, I confirm that I have read, understood, and voluntarily agreed to the terms of this Release of Liability.

- **Patient Signature**: _____
- **Date**: ___ / ___ / _____
- **Provider's Signature**: _____
- **Date**: ___ / ___ / _____