Abide Health Medical APC

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Consent for Treatment

Purpose of Treatment

I, the undersigned, voluntarily agree to receive behavioral health treatment and/or counseling services from **Abide Health Medical**, which may include mental health therapy, medication management, substance use treatment, and/or other behavioral health services as appropriate. I understand that the goal of this treatment is to improve my overall mental and emotional well-being.

Nature of Treatment

I understand that the treatment may include the following:

- **Psychotherapy or Counseling**: Talk therapy, individual therapy, group therapy, and/or family therapy.
- **Psychiatric Services (if applicable)**: Evaluation, medication management, and the possible use of psychiatric medications as part of my treatment plan.
- **Substance Use Treatment (if applicable)**: Assessment, counseling, support, and referrals related to substance use.
- **Other Services**: Additional services may be included as determined by my treatment team, such as case management, crisis intervention, or referrals to other providers.

I also understand that treatment may involve **collaborative decision-making** between myself and my healthcare provider(s) to tailor the treatment plan to meet my individual needs.

Voluntary Participation

I understand that my participation in treatment is voluntary, and I may choose to discontinue or refuse treatment at any time. However, I understand that doing so may impact the effectiveness of my care and the treatment outcomes. I also understand that if I discontinue treatment, I may request a referral to another provider.

Risks and Benefits of Treatment

I understand that all treatment carries certain risks, including but not limited to:

- **Emotional Discomfort**: Some therapy or treatment processes may bring up painful or difficult feelings.
- **Medication Side Effects**: If medications are prescribed, there may be side effects that vary in severity. I am encouraged to communicate any concerns about medications with my clinician.
- **Effectiveness of Treatment**: The success of treatment is not guaranteed, and different therapies work differently for each individual.

The potential benefits of treatment include improving my emotional health, learning better coping skills, managing mental health or substance use symptoms, and improving my quality of life. However, I understand that the results of treatment cannot be guaranteed.

Confidentiality and Limits to Confidentiality

I understand that my personal health information will be kept confidential as required by **HIPAA** (Health Insurance Portability and Accountability Act), and **Nevada state law**. My health information will not be shared without my permission, except in the following circumstances:

- **Risk of Harm to Self or Others**: If I express thoughts of harming myself or others, the clinic is required to take steps to ensure safety, which may include notifying appropriate authorities or individuals.
- **Child or Elder Abuse**: If there are concerns of child or elder abuse, the clinic is required by law to report such concerns to the authorities.
- **Court Orders**: My treatment information may be released if ordered by a court of law.
- **Coordination of Care**: If necessary, my information may be shared with other healthcare providers involved in my treatment, such as a primary care physician or psychiatrist, with my consent.
- **Specific Protections for Substance Use Treatment**: If I am receiving substance use treatment, I understand that my substance use treatment records are protected under **42 CFR Part 2** (federal regulations governing confidentiality in substance use treatment). My records cannot be disclosed without my written consent, except in certain cases as permitted by law (e.g., for emergencies, research, or audit purposes).

Patient Rights

I understand that I have the following rights under **Nevada state law** and **HIPAA**:

- **Right to Inspect and Copy**: I have the right to inspect and obtain a copy of my health records.
- **Right to Request Corrections**: If I believe any information in my records is incorrect, I can request corrections or amendments.
- **Right to Request Restrictions**: I can request restrictions on how my health information is used or disclosed.
- **Right to Confidential Communications**: I can request that the clinic contact me in a specific manner (e.g., by phone, mail, or email).
- **Right to Receive a Copy of the Privacy Notice**: I have the right to receive a copy of the **Notice of Privacy Practices** and be informed about how my information will be used and shared.

I also acknowledge that I can voice concerns or file complaints about my care, treatment, or the clinic's practices without fear of retaliation.

Financial Responsibility

I understand that I am responsible for the payment of all services provided, including co-pays, fees, or any amounts not covered by my insurance. I agree to comply with the clinic's billing policies, including any cancellation or missed appointment fees, and I will promptly notify the clinic of any changes to my insurance information or financial situation.

Consent for Use of Electronic Communication

I consent to the use of electronic communications (e.g., email or text messages) for scheduling appointments, billing, or communicating information about my treatment, understanding the limitations to confidentiality in this form of communication. I understand that any information transmitted electronically may have security risks, and I acknowledge that I have been informed of these risks.

Consent for Telehealth Services (if applicable)

I consent to receiving treatment via **telehealth** (e.g., video or phone calls) for mental health services, as an alternative to in-person visits. I understand that telehealth services are provided via electronic communications and may involve potential risks, including interruptions, unauthorized access, and technical difficulties. I have the option to request in-person treatment at any time.

Minor Consent for Treatment

If I am under the age of 18, I understand that **Nevada law (NRS 433.400)** allows me to consent to my own mental health or substance use treatment if I am **14 years of age or older**. If I am under 14, my parents or legal guardian will need to provide consent for treatment. However, I understand that I may request confidentiality regarding certain aspects of my treatment, and my provider will explain any limitations to confidentiality in such cases.

Substance Use Treatment (42 CFR Part 2)

If I am seeking treatment for a substance use disorder, I understand that **42 CFR Part 2** provides additional confidentiality protections for my substance use treatment records. These records cannot be disclosed without my written consent, except in very specific situations as defined by law (e.g., emergency situations, court orders, or audits).

Acknowledgment of Rights

I understand that I have been informed of my rights as a patient, including the right to:

- Participate in my treatment planning,
- Request a second opinion or a referral to another clinician,
- Review and request copies of my treatment records,
- Withdraw my consent for treatment at any time, which will not affect my right to care for future services.

I also understand that I am encouraged to be an active participant in my treatment, and I have the right to ask questions and discuss the treatment process with my clinician at any time.

Consent for Treatment

By signing below, I acknowledge that I have read, understood, and had the opportunity to ask questions about the information provided in this document. I agree to participate in the treatment process as outlined above and provide my informed consent to receive care from **Abide Health Medical**.

Patient Signature: _____ Date: ___ / ___ / _____

Parent/Guardian Signature (if minor): _____ Date: ___ / ___ / _____