Universality Health Care Clinic
547 Riverside Drive Suite #A
Salisbury, MD 21801
Phone: (443) 831-3983
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INFORMED CONSENT FOR TREATMENT

Name:

Date of birth:

I agree and consent:
Psychiatric Rehabilitation Program(PRP)

Intensive Outpatient Program/Outpatient Substance Abuse Program

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Universality Health Care LLC.
2. I have been given information regarding my rights and responsibilities as a patient
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services. I understand that I may be responsible to pay a co pay and that it is payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my therapist/psychiatric NP at any time. I understand that may also contact the licensing board which regulates my therapists/psychiatric NP/Psychiatrist professional practice.
6. I am freely choosing to enter treatment, and I understand that I may discontinue at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

Patient print name/signature/date

Authorized signer name/relationship/signature/date