Universality Health Care Clinic
547 Riverside Drive Suite #A
Salisbury, MD 21801
Phone: (443) 831-3983
Fax: (443) 733-6050

INFORMED CONSENT FOR TREATMENT

I hereby request:

Name

Date of Birth

be accepted for psychiatric health treatments such as: Psychotropic medication management, psychiatric consultation, psychiatric evaluation, substance use disorder (IOP), psychiatric rehabilitation program (PRP), individual/family/group therapy

I agree and consent to the following statements.

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