Front Range Family Psychiatry LLC
124 Main Ave N
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(406) 403-0423 Fax

Informed Consent Form for Psychiatric Services

General Information

The relationship between a Psychiatric Provider and their client is unique in that it is very personal yet also a contractual agreement. A therapeutic relationship is formed between the provider and the client with a bond of trust, caring, respect, an agreement on the goals of therapy, and collaboration on the work of treatment. This consent form provides a clear framework for the work of treatment, which provides a clear understanding of how our relationship will work and what each of us can expect. Please feel free to discuss any of this with me at any time.

The Therapeutic Process

You have taken a very positive step by deciding to seek help in your mental wellness. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures nor magic pills. I can not promise that your behavior or circumstance will change. However, I can promise to be supportive of you and do my best to understand you and any repetitive patterns, as well as to help you clarify what you want for yourself. I will accompany you on your journey to self-discovery and mental wellness.

Confidentiality

Each session content and all relevant materials to your treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are as follows:

1. If a client threatens or attempts suicide or otherwise conducts themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the provider has a reasonable suspicion that a client or other named victim is the perpetrator of, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years old.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and #4 above.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I, as your provider, may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but do not feel it is appropriate to engage in any lengthy discussions in public outside of the therapy office. If we have previously had a social relationship, our therapeutic relationship will not be discussed in any setting outside of the therapy office. Your confidentiality in receiving care is vitally important to me.

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to, and authorizes services, by Christina L. Borst, DNP PMHNP APRN of Front Range Family Psychiatry LLC. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

The undersigned understands that they have the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Parent, Legal Guardian, or Conservator (if applicable) Date Signed

_____ _____

Signature of Witness (if applicable) Date Signed