Carencia

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Consent To Treatment

I understand the decision to participate in treatment, including its direction, is voluntary. I understand Carencia Healthcare, LLC will provide information relevant to my decision making including the purpose of proposed treatment(s), viable alternatives, foreseeable risks and benefits, and the potential for lack of benefit. I understand that consenting to treatment is an evolving process and not a simple one-time "permission." I understand there will be on-going conversations and decision making that will allow for review of previously discussed information and new information, with respect for my autonomy along the way.

I understand treatment is not guaranteed by a physician and can be provided solely by an accredited and licensed Nurse Practitioner.

I understand that, if prescribed a medication classified as a controlled substance, I will be required to submit a point-of-care (POC) urine drug screen (UDS) prior to treatment initiation and random UDS thereafter supported by treatment practice guidelines and suggestions. I understand that, when prescribed controlled substances, POC tests are used for visit decisions, and the Carencia provider will always send out the specimen to a lab for result confirmation, as is the standard of care, with the possibility of additional fees unrelated to Carencia based on lab fees/insurance.

I understand that controlled stimulant medications, such as Ritalin, Vyvanse, and Adderall products, commonly prescribed for Attention-Deficit Hyperactivity Disorder, are not currently prescribed by Carencia Healthcare providers.

I understand that Carencia Healthcare has an attendance policy that applies to me. There are fees associated with late cancel and missed appointments addressed further in the financial agreement. After three (3) late cancel or no show appointments, Carencia will terminate services and refer out to another community provider.

I hereby give my consent to Carencia Healthcare, LLC, and authorize them to provide my mental health treatment. I understand that Carencia Healthcare, LLC will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Carencia Healthcare, LLC, to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read, and I fully understand this Consent to Treatment form and understand I will have the opportunity to discuss my condition and treatment(s) with the care provider.

Patient Name (Printed): _____

Patient Signature: _____ **Date:** _____

Guardian Signature (for minors): _____ **Date:** _____

Relationship To Patient: _____