Carencia
Mental Healthcare

Consent To Treatment

I hereby consent to receive medical and mental health treatment from providers at Carencia. This treatment may include, but is not limited to, medical examinations, diagnostic tests, medications, surgical procedures, psychotherapy, counseling, and other mental health services as deemed necessary by my healthcare provider. I understand that my healthcare provider will explain the nature, purpose, risks, and benefits of the proposed treatments and procedures, including potential side effects and alternative treatment options.

I understand I have the opportunity to ask questions and receive satisfactory answers. I acknowledge that I have the right to refuse any treatment or procedure at any time.

I understand that my healthcare provider may share my medical and mental health information with other healthcare professionals involved in my care, as necessary, to provide the best possible treatment. My medical and mental health information will be kept confidential and will only be disclosed as required by law or with my consent.

I understand that I have the right to receive information about my diagnosis, treatment options, and prognosis, participate in decisions about my care, refuse treatment, and receive respectful and considerate care.

I understand treatment is not guaranteed by a physician and can be provided solely by a licensed Nurse Practitioner or other healthcare provider.

I understand that if my provider feels that care at Carencia is not sufficient for my treatment needs, or if I need a higher level of care, I may be referred outside of Carencia for further care.

I understand that certain behavior including, but not limited to: threats, offensive or verbally abusive behavior, physicially offensive behavior, or other inappropriate conduct or boundary violations, as determined by Carencia staff or provider, will immediately lead to termination and transition of care outside of Carencia.

I understand that if I am currently involved, or become involved, in a legal matter that may require subpeona of records or Carencia staff court appearances, I may be referred out to a clinic or provider that specializes in forensic/legal treatment. I also understand that if for any reason my records or my providers are subpeonaed by the court, court appearance and record fees may apply.

I understand medications have inheritant risk, whether allowing administration of medication at Carencia, complementary alternatives to medicine, or procuring medications at a pharmacy, I understand I am consenting to treatment and acknowldge the risks of medications in my treatment plan.

By signing below, I acknowledge that I have read and understood this Consent to Treatment form and that I consent to the treatment and services described above.

Patient Name (Printed): _____

Patient Signature: Date:

Guardian Signature (for minors) and relationship to patient:
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