R & R Psychiatric Care
2680 S Val Vista Dr, Building 15 Suite 185, Gilbert, AZ 85295
Office (480) 630-4434 Fax (480) 630-5285 www.rrwellness.org

Treatment Consent

Consent to Services: I voluntarily consent to participate in psychiatric and behavioral health treatment by staff at R & R Psychiatric Care PLLC. Treatment may be provided by a psychiatric nurse practitioner, a licensed counselor, a medical assistant, or a student intern supervised by any of the professionals listed. Services may include evaluations, assessments, diagnostic testing, clinical therapies, psychotherapy, referrals, and/ or medication management. I give permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; (2) acknowledgment of my provider informing me of treatment options including benefits and risks, and (3) I consent to treatment at this office or any other satellite office under common ownership.

Risks & Benefits: Behavioral health treatment has both benefits and risks. I understand that there may be varying success in treatment depending on severity of complaints, ability to be honest and introspective, and motivation to apply what is learned. I understand that, although R& R Psychiatric Care providers recommend treatments that may help me, there are no guarantees that my condition will improve from treatment. A small number of clients may not improve because of treatment or may terminate before it is clinically indicated. I understand that I have the right at any time to discontinue services, the right to discuss my treatment plan with my provider about the purpose, potential risks, and benefits of any treatment ordered for me, and the right to discuss any concerns I have or any difficulties I experience during treatment with my provider. I understand that while R & R Psychiatric Care providers have explained the treatment to me, there may be problems that develop, and it is my responsibility to inform my health care provider if there are any unexpected changes in my condition or if any problems arise relating to my treatment. If an emergency develops, I will call 911 and go to an emergency room.

Medications: My provider may recommend medication as part of my treatment, including medications for FDA-approved diagnoses and indications as well as medications being used off-label based on symptoms and the provider's clinical expertise. In addition, the provider may recommend over-the-counter vitamins and supplements to address symptoms and treatment goals. While the provider will educate me during appointments on these treatments, acceptance of prescriptions and recommendations constitutes my consent for these treatments. For any controlled substances, I also agree to use as prescribed and as outlined in Clinic Policies. I understand that not all patients may have success with medications, and that sometimes several different medications may be tried before there are improvement in symptoms. Medications may have side effects that I agree to discuss with my provider and pharmacist. I understand that medication treatment could have effects on my brain, body, consciousness, emotions, actions, sleep, memory, judgment, coordination, stamina and sexuality. Many medications require strict adherence to dosage, frequency, close follow-ups and sometimes regular blood tests. I agree to notify my provider if there are any changes to my health conditions, medical medications, or anything else that could become a safety concern, so that the provider can change medications if needed. This consent indicates my understanding of these responsibilities and risks.

Female Clients: I attest, to the best of my knowledge, that I am not pregnant. I understand the effects of medication on unborn children are not always known. I further attest that if I am pregnant or suspect that I may be pregnant, or attempt to become pregnant, I will notify the provider or staff immediately. Understanding this, for any medication I take, I hold the provider and staff harmless for any defect to my unborn child that may arise from the use of these medications.

Authorization To Access Rx History: I hereby authorize R & R Psychiatric Care, PLLC and any of its providers or staff to access my historical prescription drug information.

Attestation of Informed Consent: I had the opportunity to have my questions answered pertaining to treatment. I have also been given an opportunity to decline treatment. My consent for treatment has been given voluntarily. By signing below, I certify that I have read and understand the terms stated in this Treatment Consent and that I give my consent for treatment.

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ACKNOWLEDGEMENTS

1. I have received a copy of this Treatment Consent, I have read and understand the information, have had an opportunity to ask questions about this information, and agree to all terms and will abide by these policies.
2. I acknowledge that R & R Psychiatric Care may update this form from time to time, that all policies of the clinic can be viewed on the clinic website www.rrwellness.org/faq, and that continuing to receive services at the clinic implies my consent to future updates.
3. I agree that a photocopy or electronic copy of this consent shall be considered as valid as the original.
4. This consent will expire 60 days after the date of closure of care and discharge from R & R Psychiatric Care.
5. If applicable, I attest that I am the legal guardian and have the right to consent on behalf of this minor.

_____ _____ _____

Signature of Client or Legal Guardian Printed Name Date

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Name of Client if a Minor