Consent for Treatment

Patient's Legal Name: _____
Date of Birth (MM/DD/YYYY): _____

I, the undersigned patient (or personal representative), hereby provide consent for treatment by iTrust Wellness, LLC, herby referred to at iTrust or iTrust Wellness. I understand and agree to the following:

1. Nature of Treatment:
   - Scope of treatment. I acknowledge that I have been informed about the nature of the mental health treatment to be provided. This may include psychiatric evaluations, counseling, medication management, and other appropriate interventions deemed necessary by the provider.
   - Medication Management. I acknowledge that if medication is considered an appropriate part of my treatment, the provider may prescribe and monitor medication. I understand that it is my responsibility to strictly adhere to prescribed dosages, report any side effects or concerns to my provider promptly, and attend follow-up appointments for medication monitoring and adjustment. I understand that if I take certain medications prescribed by my provider, I may be prohibited from operating heavy machinery (including a personal automobile) while under the influence of said medication. I understand that my provider will either inform me of these risks and contraindications or refer me to material related to my prescription that describes and explains the same.
   - Risks and Benefits. I understand that treatment, like any medical intervention, carries potential risks and benefits. The potential benefits of treatment may include symptom relief, improved functioning, and enhanced well-being. Risks may include possible side effects of medications, adverse reactions to medications, adverse interactions with other medications I am concurrently taking, and the possibility that treatment may not achieve the desired outcome. I do not expect the provider to be able to anticipate and explain all the risks and complications and wish to rely on the provider to exercise judgment during the course of any procedure or treatment, which the provider believes is in my best interest at the time of service.
   - Treatment Alternatives. I have been informed about alternative treatment options and their respective risks and benefits. I understand that I have the right to explore and choose alternative treatments or seek a second opinion if desired.
   - Emergency Situations. In the event of an emergency where immediate psychiatric intervention is necessary to protect my safety or the safety of others, I authorize iTrust Wellness, LLC to take appropriate actions in my best interest, including hospitalization, if required. I understand that any emergency intervention or emergency treatment carries potential risks, including, but not limited to, my injury or disability, depending on the circumstances of the intervention and treatment.

2. Confidentiality:
   - Privacy Practices. I understand that my personal health information will be kept confidential and will only be shared with authorized individuals involved in my care, unless required by law or in situations where there is a concern for the safety of myself or others. I have received and read the Notice of Privacy Practices detailing the privacy policies of iTrust Wellness, LLC.

3. Patient Responsibilities:

- Prescription Medication and Substance Use Transparency. I understand that it is my responsibility to fully inform my provider of all other medications I am currently taking, and all other treatment or therapy I may be receiving from other providers not affiliated with iTrust Wellness, LLC. I understand that it is my responsibility to promptly inform my provider if I begin taking a new medication, or discontinue taking a medication, and to inform my provider if I begin receiving a new type of therapy or treatment from another provider. I understand that it is my responsibility to inform my provider of any illicit, illegal, non-prescribed, or any other drug or substance I am currently consuming on a regular or irregular basis. I understand that my failure to fully inform my provider about all medications or substances I consume, and all treatment I am otherwise receiving, carries potential risks, including, but not limited to, injury or disability resulting from adverse medication reactions. I understand and acknowledge that iTrust Wellness, LLC, and its providers, shall not be responsible for adverse reactions, injuries, disability, or death that results from my failure to fully inform my provider of all other medications and treatment I may be consuming and/or receiving.
- Financial Responsibility. I understand that I am financially responsible for the services rendered by iTrust Wellness, LLC. I will comply with the financial policies of the practice, including payment for services and any applicable co-pays, deductibles, or uncovered costs.

4. Discharge Procedures:

- Right to Withdraw Consent. I understand that I have the right to withdraw my consent for treatment at any time. I acknowledge that it is important to communicate any decision to withdraw consent to iTrust Wellness, LLC promptly.
- Obligations Upon Discharge. I understand that, upon my discharge as a patient of iTrust Wellness, LLC, it is my responsibility to find follow-up care to ensure the continuity of my treatment (including medications).

By signing below, I acknowledge that I have read and understand the information provided in this Consent for Treatment form, in addition to the iTrust Wellness, LLC Patient Policies, a copy of which has been provided to me separately for my review.

_____

Patient (or Legal Representative) – Print or Type Name

_____ _____

Patient (or Legal Representative) – Write or Type Signature Date Signed