Consent to Treat

Part B

The purpose of this consent form is to obtain your permission to perform the evaluation necessary to identify any condition(s) that might require treatment as part of your plan of care. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment.

*I voluntarily request a provider, or the designees as deemed necessary, to perform reasonable and necessary medical/mental health examination, testing and treatment for the condition which has brought me to seek care at this practice or one that has been identified._____ Initials.

You have the right to be informed about any condition identified and any/all recommended treatments including, but not limited to, imaging, labs, referrals. You may then decide whether or not to undergo any suggested treatment after being informed of the potential risks, benefits, and alternatives involved. _____ Initials.

I agree to healthcare communication via email, phone call and or text messages. I understand I may opt out of text and or email messaging by notifying any staff member. _____ Initials.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I understand I am responsible for additional fees that may occur. _____ Initials.

If signing as a parent or guardian, I hereby represent that I am legally empowered to make such decisions._____ Initials.

By signing below, you are indicating that you understand that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended, along with potential risks and benefits. The consent will remain fully effective until it is revoked in writing. _____ Initials.

Confidentiality
Also, by signing below you attest that you have been informed of confidentiality and exceptions. That we do not offer any emergency services, and to go to the ER or call 911 should you develop suicidal intent, plan, or dangerous impulsivity. You are committed to providing your current location at the outset of each video session, both to verify that you, the client is located in a state in which this clinician is licensed, as well as for use in case of emergency._____ Initials.

You attest that you have been informed of the risks and benefits of using video technology for therapy sessions and agreed to conduct sessions by video. You are aware that occasionally another Destiny Health clinician may be present at the beginning of a session to ask to observe the session, and that the client may consent to or refuse the observation at that time. You have been informed that for safety reasons, no session will occur in a vehicle while it is moving. You have been reminded of the payment policies including, but not limited to, your financial responsibility for any session that is not paid for by their health insurance company, as well as standard charges for no shows and late cancellations._____ Initials.

You confirmed that you understood the above policies and procedures and agreed to be bound by them._____ Initials.

Print Your Name:_____. Sign:_____. Date: _____