Fireweed Health Care, Inc.

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INFORMED CONSENT FOR PSYCHOTHERAPY & MEDICATION MANAGEMENT SERVICES

ADULT SERVICE AGREEMENT

NAME:_____ DATE OF BIRTH:_____

INFORMED CONSENT FOR PSYCHOTHERAPY & MEDICATION ASSISTED TREATMENT: Please read all materials very carefully and place a checkmark towards your answer after reading each question to demonstrate your understanding. When you are treated at Fireweed Health Care you are agreeing to these policies.

What Is a Psychiatric Mental Health Nurse Practitioner PMHNP?

The role of the Psychiatric Mental Health Nurse Practitioner (PMHNP) is to assess, diagnose and treat mental health needs of patients. PMHNPs provide psychotherapy and prescribe medications for patients who have mental health disorders or substance use issues. PMHNPs may also provide physical and psychosocial assessments and treatment effectiveness evaluations.

PSYCHOLOGICAL SERVICES

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But there are no guarantees about what will happen. Psychotherapy requires an active effort on your part. To be most successful, you will have to work on things we discuss outside of sessions.

APPOINTMENTS

Appointments will be Initial evaluation, 1st Follow-up, counseling appointments and Medication Management Appointment. The frequency of sessions will vary according to patient needs and preferences. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on-time; if you are late, your appointment will still need to end on-time.

_____I agree to keep, and be on time to, all my scheduled appointments with the provider.

_____I agree to conduct myself in a courteous manner in the clinic and providers' office.

_____I agree not to arrive at the office intoxicated or under the influence of drugs/alcohol. If I do, the staff will not see me, and I will not be given any medication until my next scheduled appointment.

_____I agree not to sell, share, or give any of my medication to another person. I understand such mishandling of my medication is a serious violation of this agreement and may result in my treatment being terminated without recourse or appeal.

_____I agree not to deal, steal, or conduct any other illegal or disruptive activities in the vicinity of the providers' clinic, or anywhere else.

_____I agree that my prescription can only be given to me at my regular office visits. Any missed office visits will result in my not being able to get medications until the next scheduled visit.

_____I agree to keep my medications safe and secure and that it is my responsibility to store them in a safe or secure location. Children and pets can die from a single exposure. LOST OR STOLEN, DAMAGED OR OVER-CONSUMED MEDICATION WILL NOT BE REPLACED regardless of the reason.

_____I agree not to obtain psychotropic medications from any other provider.

_____I agree that medications alone may not be sufficient treatment and I agree to participate in counseling, groups, 12-step programs, formal outpatient or inpatient, or any other kind of treatment I feel supports me in recovery from disease or addiction. I will sign a release of information (ROI) for my treating provider to review my participation in such programs.

_____I agree to cooperate with witnessed or unwitnessed urine drug testing whenever requested by medical staff, to confirm if I am using my prescribed medication and to confirm I am not using any other prescribed, unprescribed or illicit substances which might pose a risk to my health and well-being.

_____I agree to report my history and my symptoms honestly to my provider and inform staff of all other providers and dentists whom I am seeing; of all prescription and non-prescription drugs I am taking; of any alcohol or other drugs I am taking or using; and whether I have become pregnant or have developed hepatitis.

_____I agree to sign ROI's as requested by my provider for communication with other providers, pharmacists, counselors, therapists, probation officers and other parties directly or indirectly involved in my care when my provider has decided that open communication about my care, on my behalf, is necessary.

Your signature below indicates that you have read this Agreement and agree to the terms.

_____ _____

Signature of Patient or Personal Representative Date

_____

Description of Personal Representative's Authority

Printed Name: _____