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INFORMED CONSENT FOR PSYCHIATRIC SERVICES

Client Name: Client Date of Birth:

Options Location: Options Counseling and Family Services Location:

Evaluation and Medication Assisted Treatment

I authorize the staff of Options Counseling & Family Services to complete a psychiatric assessment and provide medication management as appropriate to treat my behavioral health condition. This request for psychiatric services at Options is voluntary. I understand that I may ask questions about my treatment at any time. I understand that I may stop my treatment at any time.

I understand that medication management is a specialized service provided while I'm engaged in mental health treatment. When I have been discharged from mental health treatment and/or my medication is stabilized, my provider will work to transfer my prescriptions to my primary care provider.

I understand that all services are intended to address an identified behavioral health condition and that services are expected to assist me in making improvements to that identified behavioral health condition. I understand that the services and supports offered to me will be based on my medical need and specific behavioral health condition.

Client Initials

Taking Prescribed Medications

By working with the provider, I agree to take my medications as prescribed. I will inform my provider regarding updates to my substance use, use of supplements, or anything else that may impact how my body processes the medications I'm prescribed.

I will inform my provider of any new medications prescribed by alternate programs.

I will contact my provider immediately if I experience any new side effects or if my side effects worsen.

Lab work, including urine analysis and blood draws, may be requested by my provider before receiving a prescription. I understand I will be required to complete these labs. My provider will review the lab results before starting or continuing my medications.

By initialing I agree that I have read and understand this section:
Client Initials

Requesting Refills

When possible, Options utilizes electronic prescribing for controlled medications. All prescriptions for controlled substances are sent directly to the pharmacy of your choice; please identify one pharmacy.

My prescriptions will be refilled at the time of my medical appointment or shortly after. I understand that not all psychiatric providers work all days of the week. If I need to request a refill between appointments, I will call my pharmacy to request a medication refill and will allow at least five business days for refills to be completed.

For controlled medications that require hardcopy prescriptions, I will contact my psychiatric provider's office directly to request a new prescription. I will allow up to five business days for completion of hardcopy

prescriptions.

By initialing I agree that I have read and understand this section:
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Outcome Measure

For the purpose of monitoring and improving services, I acknowledge that I may be asked to fill out a questionnaire related to my symptoms and how I feel my treatment is progressing. Information from the questionnaires may help me and my provider monitor improvement and make adjustments in my medications, if necessary. I understand that my personal information is kept strictly confidential. I understand that I may refuse to participate at any time.

By initialing I agree that I have read and understand this section:
Client Initials

Telemedicine

I consent to receiving services by telemedicine, I authorize the staff of Options Counseling & Family Services to provide medical services via electronic means through interactive videoconferencing equipment and understand that, at this time, there is no known risk involved with receiving care this way. The process will be explained to me and I will be able to view the equipment prior to participating in any services. I acknowledge that my participation in telemedicine is voluntary and I understand that I have the right to refuse or stop treatment at any time. Refusal or stopping treatment may have an effect on my condition, it may worsen, stay the same, or get better.

By initialing I agree that I have read and understand this section:
Client Initials

My privacy and confidentiality will be protected. I am aware that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. While receiving services via telemedicine, I will be notified as to who is in the room at the remote site. The health care providers at both my location and the remote video site will have access to any relevant medical information about me including any psychiatric and/or psychological information, substance abuse records, and mental health records.

By initialing I agree that I have read and understand this section:
Client Initials

My signature indicates that I have read and understand/agree to the provided policies, which will be used while I or my family member is receiving medication services.

Client Name Relationship to Client : ○Self○Parent/Guardian○Legal ○ CustodianOther

Other

X

Signature Certificate

Document name: INFORMED CONSENT FOR PSYCHIATRIC SERVICES

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