Consent for Psychiatric Evaluation and Treatment

1. I voluntarily consent that I will participate in a mental health evaluation and treatment by staff from WELLCORE PSYCHIATRY OF MARYLAND, LLC. I understand that following the evaluation and/or treatment, information will be provided to me concerning each of the following areas:

    a. The benefits of the proposed treatment;
    b. Alternative treatment modes and services;
    c. The manner in which treatment will be administered;
    d. Expected side effects from treatment and/or risks of side effects from medications (when applicable); and
    e. Probable consequences of not receiving treatment.

   The evaluation and treatment will be conducted by a psychiatrist or a Nurse practitioner. Treatment will be conducted within the boundaries of Maryland Law.

2. Benefits relating to Evaluation and Treatment: Evaluation and Treatment may be conducted by psychiatric and psychological interviews, psychological assessment or testing, brief psychotherapeutic interventions and medication management. It may be beneficial to me, as well as any referring professional to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of the evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, education and rehabilitation planning. Possible benefits of treatment include: improved cognitive or academic/job performance, health status, quality of life and awareness of strengths and limitations.

3. Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I agree I will be responsible for charges not covered by insurance, including copayments, deductibles, no show fees and fees relating to services such as completion of disability evaluations and copying medical records.

4. Confidentiality, Harm and Inquiry: Information from my evaluation and treatment is contained in a confidential medical record at WELLCORE PSYCHIATRY OF MARYLAND, LLC, and I consent to disclosure for use by WELLCORE PSYCHIATRY OF MARYLAND, LLC, for the purpose of continuity of my care. In accordance with the WELLCORE PSYCHIATRY OF MARYLAND, LLC, Notice of Privacy Practices and Patient Rights of Maryland law, information provided will be kept confidential with certain exceptions, including without limitation the following:

    a. If I am deemed to present an imminent danger to myself or others

b. If concerns about possible abuse or neglect arise, or
c. If a court order is issued to obtain records.

5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and treatment at any time by providing a written request to the treating clinician.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____
Patient's Name Printed

_____ _____
Signature of patient (or parent or Guardian if patient is under 18) Date

_____
Parent or Guardian's Name Printed (if applicable)