2nd CHANCE

Phone: (602) 464-9576
www.2ndchancetreatment.com

Full Consent to Treatment - Psychiatric Services

Individuals Seeking Mental Health Services Must Complete This Form Prior to Your First Appointment.

If you are a parent or legal guardian of a minor who is receiving treatment, you agree that you are providing this consent on behalf of your minor child. References to "I", "my" and "you" throughout this form include the patient and, as applicable, any parent/legal guardian.

CONFIDENTIALITY

Under most circumstances, the communications between a provider and patient are held confidential. 2nd Chance recognizes that confidentiality is essential to effective treatment. We believe that for treatment to work best, you must feel safe about sharing personal information with your provider. When you share information with your provider, he or she will respect the importance of that information. Therapy records are destroyed 7 years after your last contact with us in a way that protects your privacy. Under most circumstances, all information about you obtained in the therapy process (including your status as a client) is confidential and will be related to other parties only with your express written consent. However, there are circumstances in which we may share information about you without your consent. All interactions with 2nd Change Treatment Center, PLLC, including scheduling of or attendance at appointments, content of your sessions, progress in therapy, and your records are confidential. No record of therapy is contained in any academic, educational, or job placement file. You may request in writing that the therapy staff release specific information about your therapy to persons you designate:

- Information released to other professionals involved in your treatment. Most commonly, this would be the other members of your treatment team at 2nd Chance.
- If you are under 18, your parents or legal guardian(s) may have access to your records and may authorize their release to other parties.
- If you are reasonably suspected to be in imminent danger of harming yourself or someone else.
- If you disclose abuse or neglect of children, the elderly, or disabled persons.
- If you disclose sexual misconduct by a provider.
- In criminal proceedings.
- In legal or regulatory actions against a professional.
- Upon the issuance of a court order or lawfully issued subpoena
- Where otherwise legally required

The above is only a summary. If you have questions about specific situations or any aspect of the confidentiality of 2nd Chance records, please ask a member ofthe therapy staff.

CONSENT TO TREATMENT

The psychiatric treatment and therapy process is a partnership between you and your 2nd Chance Treatment Center (2nd Chance) provider to work on areas of dissatisfaction in your life or assist you with life goals. For treatment to be most effective, it is important that you take an active role in the process. This involves keeping scheduled appointments, listening, and following your provider's directions, being honest with your provider, and following medication instructions agreed upon with your provider.

Treatment can have both benefits and risks. While treatment can be of benefit to most people, medication does not always have the desired effect on every individual. The treatment process also can evoke strong feelings and

sometimes produce unanticipated changes in one's behavior. It is important that you discuss with a provider any questions or discomfort you have regarding therapy or medication, or any behavioral changes or side- effects you may be experiencing.

In addition to the above understanding about your treatment relationship with 2nd Chance providers:

- You consent to evaluation and treatment with mental health services as ordered by your physician and / or requested by your family.
- You understand that consent to this treatment can be revoked at any time during the treatment process. You also understand that the withholding consent does not prejudice future provision of appropriate services and supports to persons.
- You have been given an opportunity to select a provider from 2nd Chance prior to the consult, including a review of your provider's credentials.
- You understand that federal and state law requires health care providers to protect the privacy and the security of health information. You understand that 2nd Chance will take steps to make sure that your health information is not seen by anyone who should not see it.
- You understand that your healthcare information may be shared with other individuals for scheduling and billing purposes.
- You understand that you will not be prescribed any narcotics, nor is there any guarantee that you will be given a prescription at all.
- You understand that you have the right to request a copy of your medical records which will be provided to you at reasonable cost of preparation, shipping, and delivery.
- You understand that 2nd Chance has offered to answer any questions concerning procedures or treatment.

Please note that during the COVID-19 pandemic, the visit might be via telehealth to safely provide care. The session will be conducted on a HIPAA compliant platform and the visits will not be recorded. A telehealth visit will not cost any more than an office visit.

In accordance with state laws, consent for treatment of a minor can only be authorized by a current legal guardian for the minor. If the parents of a minor are separated, treatment is provided to the minor only with the written consent of both parents. If the parents of the minor are divorced, consent for treatment of the minor may be given by the parent authorized to make medical decisions for the minor. If a court of law has ordered that medical decisions for the minor are to be made jointly by the minor's parents, then consent of both parents is required for treatment of the minor. In the case of minors, as defined by state law, parents may request information about their child's diagnosis or treatment. While release of this information will be provided, it is best that the process be a collaborative one involving the minor, parent, and clinician in order to maintain the rapport established between the minor and clinician since rapport is vital to treatment success. Therefore, unless there is a safety concern, the minor would be consulted about the disclosure and encouraged to share the information with the parent first in order to establish better communications within the family structure.

MEDICATION

Your provider may prescribe psychotropic medication(s) to treat the conditions you report or exhibit duringyour evaluation and subsequent follow-up appointments. In order to make an informed decision, you must be provided with information (verbal and/or written) including the following:

- The nature of your psychiatric condition (diagnosis).
- The reasons for taking such medication(s), include the likelihood of improving or not improvingwithout such medication(s).
- Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit.

- The name, dosage, frequency, route of administration and duration of prescribed medication(s).
- The possible side effects of the medication(s) known to commonly occur or may possibly causebirth defects.
- Additional side effects may occur with continued administration of an Antipsychotic medication(s) if taken for *more than three (3) months*. Side effects may include persistent involuntary movements of the face, mouth, limbs, and trunk, called Tardive dyskinesia. These symptoms may be irreversible and may continue to appear even after the medication(s) has been discontinued.

NOTE: Your signature below signifies you have read and acknowledge items 1 through 5 described.
***** Your acknowledgement does not indicate that you agree to take these or other medications without completely discussing with your provider******

I understand possible side effects of the following specific types of psychotropic medications, which may include (but are not limited to):

i. ***Common Psychotropic Medications:*** dizziness, drowsiness, rigidity of muscles, and tremors.
ii. ***Lithium:*** blurred vision, diarrhea, impairment of coordination, increased urination, muscularweakness, ringing of ears, and tremors.
iii. ***Benzodiazepine***: unsteady gait, physical dependence, and after prolonged use should bewithdrawn gradually.
iv. ***Antidepressants (tricyclic or tetracyclic):*** blurred vision, constipation, dry mouth, difficulty urinating, occasional dizzy feeling after quick movements, heart palpitations, or irregular heartbeat.
v. ***Antidepressants (SSRI):*** decreased coordination and inflammation of nasal mucous membrane.

1. I understand additional possible side effects may occur when taking psychotropic medication for extended periods (3 months or longer).
2. I understand that some psychotropic medications may require certain lab tests performed at an outsidelab (depending on your insurance) on a regular basis.
   I will inform my provider of all of my known allergies on my medical history form.
3. I will inform my provider of all medications I am currently taking, including prescription, over the counter, herbal remedies, supplements, and any other recreational drug or alcohol use on my medical history form.
4. I am aware and accept that no guarantees about treatment results have or will be made.
5. I understand will discuss with my provider the probable consequences of declining recommended oralternate therapies.

Your signature below acknowledges that you understand psychotropic medication(s) you and your provider agree upon should be taken only as prescribed. You also agree to share any concerns and/or speak with your provider about risks of any medication prescribed.

SCHEDULING AND CANCELLATIONS. Please note that 2nd Chance has a Scheduling and Cancellations Policy. By signing this document, you are attesting that you understand and will comply with the Scheduling and Cancellations Policy.

FEES AND BILLING ARRANGEMENTS. You are expected to pay all fees, including co-pays for behavioral health services upfront at the time of service; however, you are not obligated to pay any fees for which another party (e.g., your employer or health plan) has contractually agreed with 2nd Chance to pay on your behalf. If you believe any of the fees you have been charged are incorrect, you must immediately contact us in writing regarding the amount in question to be eligible to receive a refund. You irrevocably waive your right to challenge the accuracy of any charge,

or otherwise receive a refund, if you fail to notify 2nd Chance in writing within fifteen (15) calendar days after the charge, that you believe the charge is inaccurate (settingforth an explanation of why).

Please note that 2nd Chance's other policies and procedures and related information are made available to you before commencing services with us. **By signing this form, you are representing that you have read these documents, understand the information found in them, and you agree to comply with them, as applicable.**

Signature

I hereby give my consent to treatment that may include recommendation of psychotropic medication. This consent is given voluntarily and without coercive or undue influence. I understand that I may seek additional information, and that I may withdraw this consent at any time by stating my intention to any member of the treatment team.

Patient's Full Name: _____ **Date of Birth:** _____

Name of Parent or Guardian (if signing on behalf of a minor patient):

_____

Patient's Signature: _____ **Today's Date:** _____

STATE REGULATIONS.

State	What You Should Know	Relevant Board Contact Information
Arizona	You are entitled to all existing confidentiality protections, including where a provider may only disclose all or part of your medical record and payment record as authorized by state or federal law or written authorization signed by you or your health care decision maker, pursuant to A.R.S. § 12-2292.	Board of Behavioral Health Examiners 1740 West Adams Street, #3600 Phoenix, AZ 85007 Main Number: 602-542-1882 Fax Number: 602-364-0890 information@azbbhe.us
Colorado	If you have a concern or complaint about the mental health professionals providing care to you, you may contact a board agency to assist you. You are entitled to the consent requirements outlined under 2 CO ADC 502-1:21.170.4. The confidentiality of your individual records, including all medical, mental health, substance use, psychological, and demographic information shall be protected with the applicable state and federal laws and regulations, as provided under 2 CO ADC 502-1:21.170.2. In addition to the above consent statements, you understand that you are entitled to explanations of the procedures that are part of the treatment, a description of the discomforts and risks, a description of the expected benefits, and a disclosure of alternative procedures with their attendant benefits and risks, as provided CRS 25.5-10-202(6).	State Board of Licensed Professional Counselor Examiners, State Board of Social Work Examiners, State Board of Marriage and Family Therapist Examiners, State Board of Addiction Counselor Examiners, and State Board of Psychologist Examiners 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-7800 Email: DORA_Customercare@state.co.us
Texas	You have been informed of the following notice:	See column to left.

	NOTICE CONCERNING COMPLAINTS -Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353, For more information, please visit our website at www.tmb.state.tx.us. AVISO SOBRE LAS QUEJAS- Las quejas sobre médicos, asi como sobre otros profesionales acreditados e inscritos del Consejo Médico de Tejas, incluyendo asistentes de médicos, practicantes de acupuntura y asistentes de cirugia, se pueden presentar en la siguiente dirección para ser investigadas: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, Si necesita ayuda para presentar una queja, llame al: 1-800-201-9353, Para obtener más información, visite nuestro sitio web en www.tmb.state.tx.us If you are prescribed psychoactive medications, you are entitled to be informed of the (A) the specific condition to be treated, (B) the beneficial effects of that condition expected from the medication, (C) the probable health and mental health consequences of not consenting to the medication, (D) the probable clinically significant side effects and risks associated with the medication, (E) the generally accepted alternatives to the medication, if any, and why the physician recommends that they be rejected, and (F) the proposed course of medication, as provided under TX. Health and Safety Code Chapter 576.025(b). If this information is provided by anyone other than the treating physician, you are entitled to meet with the physician within two working days of the information being given to you, as provided by Tx. Health and Safety Code Chapter 576.025(d).	
Utah	You understand that by agreeing to this consent form, you accept the risk of substantial and serious harm, if any. You also understand that you are entitled to an explanation of your condition and proposed health care and the risks, and that you have had the opportunity to ask associated questions. These rights are described in Utah Code 78B-3-406(3).	Utah Medical Board (801) 530-6628 (866) 275-3675 b1@utah.gov
Nevada	You are entitled to information surrounding the treatment or procedure, any significant risks involved, information on alternatives to the treatment, the name of the person responsible, and the costs likely to be occurred. You also understand that you have the opportunity to ask questions about the above information, as required by NRS 449A.106(6).	State of Nevada Board of Examiners for Marriage & Family Therapists and Clinical Professional Counselors 7324 West Cheyenne Ave., Suite #9 Las Vegas, Nevada 89