Consent to Evaluate and Treat

Patient's Name:_____DATE _____DOB_____

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health evaluation and/or treatment by staff from Well Care Services . I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the therapeutic services
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment.
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Nevada Law forLicensed Clinical Social Workers, Licensed Social Workers, Marriage and Family Therapist(I)s and Licensed Clinical Professional Counselors.
2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with clinical interviews, psychotherapy, psychiatric rehabilitation, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the 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 this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to 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 will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.
4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Well Care Services , and I consent to disclosure for use by Well Care Services staff for the purpose of continuity of my care. Per Nevada and federal mental health law, information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible child abuse or neglect arise; or 3) 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/or treatment at any time by providing a written request to the treating clinician. I understand that if my services are court ordered your treatment services may be suspended if consent is withdrawn as it will no longer permit Well Care Services to provide effective treatment and treatment continuity.
6. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

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.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative. **Date**

_____

Name of Parent, Guardian or Personal Representative. (if applicable)

Signature of witness:_____ **Date:**_____

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