

CONSENT FOR TREATMENT

I, _____, authorize and request that Tidal Mental Health, LLC provide psychological assessment, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my provider and me.

I understand that the purpose of these procedures will be explained to me and subject to my verbal agreement. I understand that I have the right to ask about other treatments for my condition and their risks and benefits.

I acknowledge that if I have questions about any of the procedures used in the course of my treatment, their possible risks, my provider’s expertise, or about the treatment plan in general, I will discuss these with my provider.

I understand this consent does not constitute a guarantee about the results of my treatment.

I understand I can terminate this consent for treatment at any time. I also understand that my provider may terminate consent for treatment at any time and will discuss the reasons with me if this should occur. Potential reasons include misusing prescribed medications, misusing provider services, frequent cancellations and/or no shows, failure to remit payment for services, etc.

I have read and fully understand this Consent for Treatment form.

Name (print) _____ Date of Birth _____

Signature _____ Date _____

Witnessed by: Sarah Smigliani, PMHNP-BC

Signature _____ Date _____