Consent for Psychiatric Treatment

Please review this information carefully. Ask any questions before signing.

CONSENT TO PSYCHIATRIC CARE

I voluntarily consent to evaluation and treatment by TrueNorth Psychiatric Nursing Corp and its treating provider(s). Services may include psychiatric assessment, diagnosis, medication management, medication initiation or adjustment, medication tapering/deprescribing when clinically appropriate, laboratory or other diagnostic recommendations, ADHD assessment/testing when offered, substance-use evaluation, medication treatment for substance-use disorders, referrals, care coordination, and other services within the provider's professional scope.

I understand that treatment is collaborative and that no specific outcome can be guaranteed. I have the right to ask questions, participate in treatment decisions, request alternatives, decline a recommended treatment, or withdraw my consent to treatment, subject to applicable law and clinical/safety considerations.

MEDICATION TREATMENT

I understand that psychiatric medications may have benefits, risks, side effects, drug interactions, and alternatives. My provider will discuss material risks and alternatives as appropriate to the medication and my circumstances. I agree to provide accurate information about medications, supplements, substance use, allergies, pregnancy status when relevant, and other health conditions that could affect treatment. I understand that medication changes should be made in collaboration with my prescriber and that abruptly stopping certain medications may cause withdrawal or other adverse effects.

TELEHEALTH CONSENT - CALIFORNIA

TrueNorth may provide services through telehealth. Telehealth uses electronic communication to allow healthcare services when the patient and provider are in different locations. I understand that telehealth has potential benefits, including convenience and improved access, and potential limitations or risks, including technology failure, interruptions, reduced ability to perform a physical examination, and privacy/security risks inherent in electronic communication.

I understand that I may request in-person care or a referral when clinically appropriate and available. I may withdraw consent to telehealth at any time without affecting my right to future care or treatment. I understand that my provider may determine that telehealth is not clinically appropriate for a particular situation and may recommend in-person or emergency evaluation. My consent to telehealth will be documented in my medical record.

☐ I consent to receive healthcare services through telehealth when clinically appropriate.

ELECTRONIC COMMUNICATION

Patient portal, email, text messaging, and voicemail may be used for administrative or limited clinical communication as permitted by practice policy. These methods are not appropriate for emergencies and may have privacy limitations. I will not use email, text, or portal messages for urgent or emergency situations. Response times are not guaranteed outside scheduled visits or normal practice operations.

I authorize the following methods when offered by the practice:

☐ Portal ☐ Email ☐ Text ☐ Voicemail

TRUENORTH PSYCHIATRIC NURSING CORP

863 Bowsprit Road, Ste 174 | Chula Vista, CA 91914
Phone: 619-614-8009 | Email: maja.ceranic.nusn@gmail.com

PRIVACY & NOTICE OF PRIVACY PRACTICES

I acknowledge that TrueNorth maintains health information in accordance with applicable federal and California privacy laws. I understand that I will be provided access to TrueNorth's Notice of Privacy Practices, which explains how health information may be used or disclosed and describes my privacy rights. Signing this form is not a blanket authorization for disclosures that require a separate written authorization under applicable law.

I understand that certain records, including some substance-use-disorder treatment information, may be subject to additional federal or state confidentiality protections. When a separate authorization is legally required, TrueNorth will obtain it.

☐ I acknowledge receipt of, or access to, TrueNorth's Notice of Privacy Practices.

INSURANCE ASSIGNMENT & FINANCIAL RESPONSIBILITY

If I choose to use insurance, I authorize TrueNorth to submit claims and disclose information reasonably necessary for eligibility verification, claims processing, utilization review, payment, and healthcare operations as permitted by law. I authorize payment of applicable benefits directly to TrueNorth when permitted by my health plan.

I understand that insurance verification is not a guarantee of payment. I am responsible for applicable copayments, coinsurance, deductibles, non-covered services, and other patient-responsibility amounts consistent with my health plan, TrueNorth's Financial Policy, and applicable law. If I choose self-pay services, I accept responsibility for the agreed charges. Fees, cancellation/no-show terms, refunds, and other billing policies are addressed in TrueNorth's separate Financial Policy.

EMERGENCIES & LIMITS OF OUTPATIENT CARE

TrueNorth is an outpatient psychiatric practice and is not an emergency service. Electronic messages and routine office communications are not continuously monitored. If I experience a medical or psychiatric emergency or believe I may be in immediate danger, I understand that I should seek immediate emergency assistance rather than wait for a response from TrueNorth. My provider may recommend a higher level of care when clinically necessary.

PATIENT RIGHTS & VOLUNTARY PARTICIPATION

I understand that I may ask questions about my diagnosis, treatment options, medications, risks, benefits, and alternatives. I may request access to records as allowed by law, request a copy of documents I sign, and raise concerns about my care. I understand that I may discontinue treatment; however, my provider may recommend an appropriate transition plan, medication taper, referral, or higher level of care when clinically indicated. TrueNorth may also terminate the treatment relationship consistent with professional obligations, practice policy, and applicable law.

ACKNOWLEDGMENT & CONSENT

By signing below, I confirm that I have read or had this form explained to me, had an opportunity to ask questions, and understand the information above. I voluntarily consent to treatment and agree to the authorizations I selected. I understand that this consent works together with TrueNorth's separate privacy, financial, telehealth, medication, and other applicable policies.

Patient Name: _____ Date of Birth: _____

Patient / Legal Representative Signature: _____

Type full legal name as electronic signature if completing electronically.

Date: _____ Relationship / Legal Authority (if not patient): _____

FOR PRACTICE USE

Provider/Witness (if used): _____ Date: _____