Psychiatric Services of Prescott, P.L.L.C

Conditions of Informed Consent for Treatment

AUTHORIZATION FOR VOLUNTARY TREATMENT: I, _____

Authorize and agree for Psychiatric Services of Prescott (henceforth, PSP) to administer such treatment as is necessary while I am receiving services. PSP will explain in detail a specific treatment or a change in treatment, such as the use of a different medication. I understand I will be offered verbal information and explanation of services being proposed, the intended outcome from my participation in the services, the nature and procedures of the proposed treatment, and the risks and side effects of the proposed treatment. I also understand I will be offered verbal information regarding the risks of not proceeding with the proposed treatment and be informed of alternatives to the proposed treatment. I understand informed consent is voluntary and I may withdraw or modify my consent to treatment at any time in writing. I understand my care is under the direction of my Medical Doctor or her designee employed by Psychiatric Services of Prescott.

RELEASE OF INFORMATION: Specific authorization is required for release of information. Please see PSP privacy notice.

PERSONAL VALUABLES: I agree that Psychiatric Services of Prescott will not be held liable for the loss or damage to any money or personal valuables that I bring with me while receiving outpatient services.

FINANCIAL AGREEMENT: I understand that I will be required to pay for services at the time they are rendered.

PARENTAL/GUARDIAN CONSENT: Your personal concerns about the services, the current well-being of your child/ward, or the fees are welcomed at any time, and we expect you to take responsibility to communicate such concerns to the Psychiatric Services of Prescott Staff. The Psychiatric Services of Prescott Staff will make every effort to ensure the safety of your child and others. As parents/guardians, you may withdraw your child from services at any time, except in life-threatening situations.

I HAVE READ THE ABOVE AND UNDERSTAND THE CONTENTS OF THIS FORM AND HEREBY AGREE AND CONSENT TO TREATMENT AT PSYCHIATRIC SERVICES OF PRESCOTT.

Client Signature: _____ Date: _____

Legally Authorized Representative/Guardian: _____

Rep/Guardian Signature: _____

Relationship to Client: _____