F.A.S.T BEHAVIORAL HEALTH CLINIC

Name:

Date of Birth:

Consent for Psychiatric Evaluation and/or Treatment

Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from **F.A.S.T Behavioral Health Clinic.** I understand that during and following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:

a. The benefits of the proposed treatment from the provider
b. Alternative treatment modes and services
c. The manner in which treatment and medication will be administered
d. Expected side effects from the treatment and/or the risks of side effects from the medications (when applicable)
e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychiatrist, a psychiatric nurse practitioner, a physician assistant, a psychotherapist, a psychologist, a licensed therapist, certified peer specialist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Texas Law for Psychiatric, Nursing, Physician Assistant, Psychological, Social Work, Professional Counseling, or Marriage and Family Counseling.

INITIALS_____

Benefits to Evaluation/Treatment: Evaluation and/or treatment may be administered with psychiatric interviews, psychological assessment or testing, psychotherapy, medication management, 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 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 treatments include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations. INITIALS_____

Charges: Fees are based on the length or type of evaluation and/or treatment which are determined by the nature of the services. I will be responsible for any charges not covered by insurance, including co-payments, deductibles, out of pocket psychiatric, psychotherapeutic, ancillary psychiatric services, and other administrative fees. Please see List of Fees.

INITIALS_____

Confidential, Harm, and Inquiry: Information from my evaluation and/or treatment is contained in a confidential medical record at F.A.S.T BHC and I consent to disclosure for use by F.A.S.T BHC staff and it's affiliated Collaborators in Care, i.e. Alamo Wellness, Primary Care Providers (WellMed), etc for the purpose of continuity of my care. Per Texas mental health law, information provided will be kept confidential with the following exemptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; 3) if a court order is issued to obtain, i.e. subpoena, etc. Disclosure of aforementioned information is determined by the authorizing such parties on the HIPAA Disclosure Form. To secure the confidentiality of myself and others seeking treatment at F.A.S.T, I will refrain from using any and all video/voice recording devices while on F.A.S.T BHC premises.

INITIALS_____

Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/ or treatment at any time by providing written request to the treating clinician. I understand some actions that automatically constitute my withdrawal.

from evaluation and/or treatment at F.A.S.T BHC include, but not restricted to I) multiple no shows/cancellations without 24 hour notice; 2) non-compliance to my individualized clinical treatment plans. My consent is valid, without expiration unless indicated. If expiration of consent is applicable, please indicate in the following field:

Expiration Date (If Applicable):	INITIALS_____

Right to Discharge from Clinic: I understand that F.A.S.T BHC has the right to discontinue my evaluation/treatment from the clinic for any of the following reasons, but not restricted to:

a. Non-compliance to my individualized treatment plan recommended by my clinician, e.g. not adhering to medication regiments
b. Multiple cancelations/no shows without 24 hour notice
c. Exhibiting behavior via face to face, email, teleconference or telephone that could be disruptive to other patients and/or staff, including but not limited to the following:
    I. Offensive actions and/or language demonstrated/spoken in the clinical setting, including to staff, or via communication platform, e.g. phone, email etc.
d. Suspected or confirmed attempts to refill medications such as benzodiazepines or controlled substances earlier than expected according to the prescription time.
e. Suspected or confirmed attempts to obtain medications prescribed at F.A.S.T BHC that another clinician has already prescribed to me. INITIALS_____

Communication With F.A.S.T BHC I understand that all communication outside the clinical setting with F.A.S.T staff about my treatment is conducted on a secure platform only during clinic hours, which are the following:

Phone: 817-987-1079 (follow phone prompts) and/or secure texting with consent.
Fax: 817-422-0781
Email: fastbehavioralhealthclinic@gmail.com for medication questions.
Secure F.A.S.T BHC Telemedicine Platform Technology
(Social media is not considered a secure platform for communication)

I also grant permission for F.A.S.T to communicate with me about my evaluation and treatment via these secure platforms unless otherwise specified. _____ INITIALS_____

***F.A.S.T BHC strives to deliver the best psychiatric treatment to those seeking our services. Should you need immediate emergency services, especially during non-business hours, please go to the nearest emergency room or dial 911. Other helpful emergency resources are listed below:

I. National Suicide Hotline I.800.273.8255

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SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (if under 18 years of age)

_____
PRINTED NAME OF PATIENT OR PERSONAL REPRESENTATIVE (if under 18 years of age)

_____
DATE