R.I.C. Health Services, LLC

Consent to Treatment

Client Name: ..... **DOB**----------

Treatment Agreement:

I agree to participate in treatment with and through R.I.C. Health Services, LLC. I understand that this treatment will be for the purposes of increasing myself/my child's mental health and physical welfare. I understand that I have the right to have any medication or prescription recommendations explained to me in full; and that I have the right to review **medications with my psychiatrist, nurse practitioner, and/or nurse representative.**

I understand that I have the right to ethical and fair treatment given, without regard to my race, religion, ethnic origin, sexual orientation, or color.

I understand that I have the right to appeal any decision made in my/my child's treatment, by first discussing it with my primary treating professional.

I understand that I may refuse treatment within 48 hours' notice. I understand that if I choose to refuse treatment or to rescind this agreement for treatment against medical advice, I will hold R.I.C. Health Services, LLC, blameless and harmless for any pain or suffering I/my child may incur as a result of that refusal or cessation of treatment. I have been given a copy of Patient Rights Policy, Grievance Process and Discharge Policy for my review.

Do you give consent for treatment as per the preceding information?

YES NO (Your Signature below indicates a yes)

(Client's Parent/Guardian if under 18)

_____ _____

Client Signature Date

_____

Parent/Guardian Date

R.I.C. Health Services, LLC

TELEHEALTH CONSENT FORM

R.I.C. Health Services, LLC

Consent to Telehealth Services

1,_____, give my explicit consent for_____,
(Client/ Parent Guardian Name If Minor) (Client Name or "SELF")
to receive therapeutic services using an alternative service delivery method that includes the use of audio-visual and/or audio only platforms when traditional service delivery is unavailable and/or places both parties at risk. I understand that such communication platforms may not be HIPPA compliant and/or may not follow typical privacy and confidentiality practices given the scope and nature of the telecommunication platform and devices used. Communication platforms & devices may include, but are not limited to the following types: Standard Telephone Calls, Computer Web Cam Programs, Skype, FaceTime, OoVoo, What's App, Messenger App, Zoom, Free Conference Call, Web-X etc. Telehealth Service Types may include the following: *Individual Therapy, Funnily Therapy, Medication Management, Group Services.*

I understand that the clinician and/or direct service staff member will take all necessary precautions to ensure that they are in a secure area that is not in hearing range of any individual(s) who is not approved to be a part of the telehealth session AND the client consents to the staff member freely speaking regarding their care during the telehealth session despite the individual(s) present on the client's end.

Consent Type:

_____Verbal Consent to Telehealth Services *(Staff signature required)*

_____Face-To Face Consent to Telehealth Services *(Client signature required)*

_____Verbal — Client DOES NOT Consent to telehealth Services *(Staff signature required)*

Client Name: _____

Client Signature: _____ Date: _____
(Client/ Parent or Guardian)

Staff Name: _____

Staff Signature: _____ Date: _____
(Staff Witness)
(ONLY IF APPLICABLE)

CONSENT TO RELEASE INFOMATION

R.I.C. Health Services, LLC

Client Name: _____ DOB: ----------

Consent to Release Info

I understand that all records obtained by R.I.C. Health Services, LLC, are protected under Federal Law Regulations and cannot be disclosed without my written consent unless otherwise permitted in accordance with Federal Law and Regulations. I authorize my/my child's treatment provider to consult with my insurance administrator, Educational, Medical and Legal Institutions, and other health/mental health care professionals and providers as necessary, to ensure the appropriateness of my/my child's care.

I understand and agree with the preceding statements regarding Release of information.

Please indicate your desire about sharing clinical information with your Primary Care Physician: Share my relevant clinical information._____(Please check)

(Client's Parent/Guardian if under 18)

_____ _____

Client Signature Date

_____ _____

Parent/Guardia n Date