HEALTHY MINDS

Healthy Minds Treatment Informed Consent

Clinicians Credentials and Supervision: All Healthy Minds clinicians are licensed in the State of Nevada to provide behavioral health care. Healthy Minds is a multidisciplinary group composed of psychiatrists, psychiatric murse practioners, psychologists, marriage and family therapists, licensed clinical social workers, licensed alcohol and drug counselors and other mental health providers. Also, Healthy Minds is a training site for UNLV School of Medicine, and your care may be provided by a licensed intern/ fellow, who will consult with their supervisor/s for education and treatment planning. You may contact any of our personnel at any time regarding treatment.

Risks and Benefits: Treatment involves some level of risk. It is possible discussing emotional and/or personal issues may lead you to experience difficult emotions including feeling anxious, nervous, upset, angry, guilty, ashamed, or depressed. For some, discussing treatment with your family and significant others may place stress on these relationships. Please talk with your counselor if this is something you are experiencing. We cannot guarantee any specific results or outcomes from treatment. However, research consistently demonstrates treatment can have a positive impact and is a valuable support for individuals in the achievement of their personal goals. We will do all we can to help you achieve your goals and have a positive counseling experience.

Emergency Care: Healthy Minds treatment providers are not on call 24-hours a day. In the event you need emergency care, please call 911 or go to the nearest emergency room. In the event you experience an emergency while at the treatment facility, you acknowledge Healthy Minds may provide personal information to first responders to assure continuity of care.

Electronic Transmission of Information:
I consent documents containing my clinical information, or those of the minor in my care, may be transmitted via email, which may not be entirely secure. I understand texting with the providers or any employees of Healthy Minds about client information does not ensure complete protection & confidentiality of the information exchanged. I understand information regarding my appointment, or that of the minor in my care, may be left on a voicemail of the phone numbers I provide, or I sign a release of information for.

Consent to Treatment: By signing this form, I voluntarily agree for me or a minor in my custody to receive a mental health and/or substance use disorders assessment and treatment, and I authorize Healthy Minds to provide such care. I fully understand and accept Healthy Minds cannot guarantee treatment will be beneficial due to factors beyond control. I agree to participate in the planning of my care, and I understand regular attendance will produce the maximum benefits. I understand the credentials of the persons providing my treatment. I agree to fees as described in my Financial Obligation. I acknowledge I have received a copy, read, and understand all the terms and information contained in the Notice of Privacy Practices, to include the Grievance Policy, as well as the Treatment Acknowledgements document, to include Exceptions to Confidentiality, Release of liability, Unaccompanied Minors policy, and the Client Rights. I acknowledge the risks and benefits describes herein.

I understand that if the patient is a minor, I am consenting to treatment on the behalf of the minor. I understand that I will declare my authority/ relationship and sign. For patients who are minors with divorced parents, I will provide a copy of the custody order detailing medical decision-making rights and access to medical records. If medical decision-making is shared, I agree to assist in informed consent being obtained from the other party.

I understand I may be discharged from Healthy Minds without formal written notice if there is a period of 30 days or more when I do not contact or attend appointments at the agency.

My signature indicates I have read, understood, and agree to the information on all pages of this document, I voluntarily agree to the above, and I consent to treatment for myself or the minor child with Healthy Minds.

Clients Printed Name	Signature	Date
Parent(s)/Guardian(s)/Legal Custodian Printed Name & Relationship	Signature	Date