R & R Psychiatric Care
2680 S Val Vista Dr, Building 15 Suite 185, Gilbert, AZ 85295
Office (480) 630-4434 Fax (480) 630-5285 www.rrwellness.org

General Consent for Care and Treatment Consent

Consent to Services: I voluntarily consent that I will participate in psychiatric and behavioral health treatment by staff at R & R Psychiatric Care PLLC. Treatment may be provided by a psychiatric nurse practitioner, a licensed counselor, a medical assistant, or a student intern supervised by any of the professionals listed. Services may include interviews, assessment or testing, psychotherapy, referrals, and/ or medication management. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

Risks & Benefits: Behavioral health treatment has both benefits and risks. Medications may have side effects, and other risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, and increased skills and resolutions to specific problems. A small number of clients may not improve because of treatment or may terminate before it is clinically indicated, although you have the right at any time to discontinue services. You have the right to discuss the treatment plan with your provider about the purpose, potential risks, and benefits of any treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your provider, or are experiencing any difficulties during treatment, please ask questions and talk with your provider.

Female Clients: I attest, to the best of my knowledge, that I am not pregnant. I understand the effects of medication on unborn children are not always known. I further attest that if I am pregnant or suspect that I may be pregnant, or attempt to become pregnant, I will notify the provider or staff immediately. Understanding this, for any medication I take, I hold the provider and staff harmless for any defect to my unborn child that may arise from the use of these medications.

Authorization To Access Rx History: I hereby authorize R & R Psychiatric Care, PLLC and any of its providers or staff to access my historical prescription drug information.

Attestation of Informed Consent: Our Clinic Policies are provided as part of this informed consent. Please review these documents carefully. By signing you indicates that you have read, understand, and agree to the information provided in each of the policies and procedures.

ACKNOWLEDGEMENTS

1. I have received a copy of this Consent for Care, have read and understand the information, have had an opportunity to ask questions about this information, and agree to abide by these policies.
2. I agree that a photocopy of this consent shall be considered as valid as the original.
3. This consent will expire 60 days after the date of closure of care and discharge from R & R Psychiatric Care.
4. If applicable, I attest that I am the legal guardian and have the right to consent for the treatment of this minor.

Signature of Client or Legal Guardian	Printed Name	Date

Name of Client if a Minor