General Consent for Treatment

To the patient: You have the right, as a patient, to be informed about your condition and the recommended medical treatment and alternative treatments, so that you may make an informed decision whether or not to undergo any treatment options discussed, after being further informed of the risks and benefits of such treatment. At this time, no specific treatment plan has been recommended. This consent form provides Psych Unlimited, PLLC providers with your permission to perform reasonable and necessary mental health 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) I consent to treatment by the Psych Unlimited, PLLC provider(s) via telepsychiatry/telehealth personal webinar sessions. (3) I further agree that if needed, I consent to treatment at any satellite office/hospital setting utilized by Psych Unlimited, PLLC providers. This consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your provider, regarding the purpose of treatment, potential risks, and benefits of treatment and any recommended tests or procedures ordered for you. If you have any concerns remaining after extensive education, regarding any test or treatment recommended by your provider, you will have the opportunity and have been encouraged to ask questions.

I voluntarily request that a provider associated with Psych Unlimited, PLLC perform a reasonable and necessary mental health examination, testing and treatment for any condition which has brought me to seek care by this practice, today and in the future. I understand that if invasive or interventional procedures are recommended, that I will be asked to read and sign additional consent forms prior to the procedure(s).

I agree to pay, Psych Unlimited, PLLC, the reasonable cost of such medical care, attention or treatment. I have been informed that missed appointments and/or cancelled payments will incur a $50 administrative fee. I agree, to indemnify and hold free and harmless of and from any and all liability for such cost and the mental health/medical care received from Psych Unlimited, PLLC, their providers and staff. If necessary, I further agree to informal mediation rather than legal remedy to resolve any issue associated with cost or care/treatment received from Psych Unlimited, PLLC providers and staff.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

________________________________ ____________________

Signature of patient or personal representative — Date

________________________________ SELF

Printed name of patient or personal representative — Representative's relationship to patient