Renewed Hope Counseling and Wellness
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Consent to Treatment

Patient Name: _____ Date of Birth: ___/___/___

I voluntarily consent to participate in psychological or psychiatric mental health evaluation, counseling, medication management, and/or treatment via in-person or telehealth from the staff at RHCW. I understand that following evaluation and/or treatment complete and accurate information will be provided concerning each of the following areas:

- Benefits of the proposed treatment
- Alternative treatment modes and services
- Manner in which treatment will be administered
- Expected side effects from the treatment and/or the risks of side effects form medications (when applicable)
- Probable consequences of not receiving treatment.

The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist/social worker, or an individual supervised by any of the professionals listed. Treatment will be conducted with the boundaries of Idaho law for psychological, psychiatric, nursing, social work, professional counseling, or marriage and family counseling.

Right to Withdraw Consent
I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician. I understand that in certain situations I may be discharged non-voluntarily from treatment. These situations include:

- If I exhibit physical violence, verbal abuse, carry a weapon onto RHCW premises, or engage in any illegal acts on RHCW premises or in the community while with my RHCW worker.
- If I refuse to comply with stipulated program rules, refuse to comply with treatment recommendations, or do not make payment or payment arrangements in a timely manner.

I understand that I will receive written notification of a non-voluntary discharge. I understand I may appeal this decision with the Clinical Director or request to re-apply for services at a later date.

Charges
Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of service. I will be responsible for any charges not covered by insurance, including co-payments, cancellation fees, and deductibles. Fees are available to me upon request.

Confidentiality, Harm, Injury
Information from the patient's evaluation and/or treatment is contained in a confidential medical record at RHCW, and I consent to disclosure for use by RHCW staff for the purpose of continuity of my care. Per Idaho mental health law, information provided will be kept confidential with the following exceptions:

1. If I am deemed to present a danger to himself/herself or others
2. If concerns about possible abuse or neglect arise
3. If a court order is used to obtain records.

Expiration of Consent
This consent to treat will be reviewed annually by the treating provider.

I have read and understand these terms, have had an opportunity to ask questions about this information, and I consent to evaluation and treatment. I also attest that I am the patient/legal guardian and have the right to consent. I understand that I have the right to ask questions of my service provider about the above information at any time.

_____ _____
Patient/Guardian Signature Date