Renovate Mental

12410 Milestone Center Dr, Suite 600
Germantown, MD 20876
Phone/Fax: 301-828-2350
customerservice@renovatemental.com

CONSENT FOR TREATMENT

I hereby authorize **Renovate Mental, LLC** to provide treatment as explained to me. I understand that while this treatment may be beneficial, as with any treatment, there are inherent risks. During treatment, I will discuss personal issues which may bring up uncomfortable emotions. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as reduction of psychiatric symptoms and potential remission of symptoms. I acknowledge, however, that no warranty or guarantee can be made as to the results of treatment.

CONFIDENTIALITY: I understand that discussions between myself and my psychiatric provider as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the provider has a duty to disclose, or where, in the provider's judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the provider, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my provider. By signing this Information and Consent Form, I am giving consent to the undersigned provider to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless the undersigned provider from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my provider believes that I am in physical or emotional danger or I am a danger to another human being, I understand that my provider is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Psychiatric treatment as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, treatment and services for me, and I understand that I may stop such treatment or services at any time.

Client Signature	Date
Provider Signature	Date