



PSYCHIATRIC TREATMENT & TELEHEALTH CONSENT FORM

Informed Consent | Your Care, Your Privacy, Your Choice

1 CONSENT FOR TREATMENT

I voluntarily consent to psychiatric evaluation and treatment by Horizon Mental Health & Wellness PLLC. Services may include assessment, diagnosis, treatment planning, medication management when clinically appropriate, education, referrals, and coordination of care.

I understand outcomes cannot be guaranteed and I may ask questions about recommended treatment, material risks, expected benefits, reasonable alternatives, and the option to decline treatment.

2 MEDICATION CONSENT

When medication is recommended, the clinician will discuss clinically relevant benefits, risks, side effects, alternatives, and monitoring. Prescribing decisions are based on clinical judgment and applicable law; no specific medication is guaranteed.

3 TELEHEALTH INFORMED CONSENT

I consent to approved electronic communication for telehealth. I understand limitations can include technology failure, privacy/security risks, and limits on portions of a physical examination. I agree to participate from a reasonably private and safe location and identify my current physical location when requested.

4 TELEHEALTH CONTACT INFORMATION

State / physical location during visits: _____

Best callback number: _____

Emergency contact / phone: _____

5 EMERGENCY PROCEDURES

Horizon is not an emergency service. If I am in immediate danger or experiencing a medical or psychiatric emergency, I should call 911 or go to the nearest emergency department. In the U.S., I may call or text 988. During an urgent safety situation, emergency services or my emergency contact may be contacted as permitted by law.

6 PRIVACY & LIMITATIONS

Horizon will take reasonable steps to protect privacy and confidentiality, subject to applicable law and recognized exceptions. Telehealth technology cannot eliminate every privacy or security risk.

7 PATIENT ACKNOWLEDGMENT

I have had the opportunity to ask questions, understand the information above, and voluntarily consent to psychiatric treatment and telehealth services.

Patient / Representative Name: _____

Signature: _____

Date: _____

Relationship / authority if representative: _____