DENT
NEUROLOGIC INSTITUTE

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DNI Behavioral Health Clinic - Consent for Evaluation and/or Treatment

Consent to Evaluate/Treat: I voluntarily consent to participate in a mental health (e.g., psychological, psychiatric) and/or addiction medicine (e.g., substance use disorder) evaluation and/or treatment by staff from DENT Neurologic Institute. I understand that following the evaluation and/or treatment, information will be provided concerning each of the following areas:

- The benefits of the proposed treatment
- Alternative treatment modes and services
- The manner in which treatment will be administered
- Expected side effects from treatment and/or risks and side effects of medications (when applicable), including risks related to substance use treatment such as withdrawal or medication-assisted treatment
- Probable consequences of not receiving treatment.

Evaluation and/or treatment may be conducted by a **psychiatrist, addiction medicine physician, psychologist, physician assistant, nurse practitioner, licensed social worker, or another individual supervised by one of the professionals listed above**.

Benefits to Evaluation/Treatment: Evaluation and treatment may include interviews, assessments or testing, psychotherapy, substance use evaluations, addiction medicine consultations, medication management (including medication-assisted treatment if needed), and recommendations on treatment length and frequency. The goal is to better understand mental health and/or substance use concerns affecting daily functioning and to guide appropriate care. Uses include diagnosis, treatment planning, recovery assessment, education, relapse prevention, and rehabilitation planning. Potential benefits may include improved mental and physical health, substance use stabilization, better functioning at work or school, enhanced quality of life, and greater self-awareness.

Charges: Fees are based on the type and duration of services provided. I understand that I am responsible for all charges not covered by insurance, including co-payments, co-insurance, and deductibles.

Release of Information Consent: I consent to the use and disclosure of relevant information for the purpose of continuity of care with my referring provider and/or primary care physician. This information may include, but is not limited to: diagnosis, participation in treatment, recent medical examination results, laboratory and toxicology results, treatment recommendations, prescribed medications (including addiction-related medications), follow-up recommendations, treatment plans, and progress notes.

Right to Withdrawal Consent: I understand that I have the right to withdraw my consent for evaluation and/or treatment at any time by submitting a written request to the treating clinician. Withdrawal of consent will not prejudice my continued access to care, except where treatment is required by law or court order.

Expiration of Consent: This consent will remain valid for the duration of my status as an active patient receiving psychiatry and/or addiction medicine services at the DENT Neurologic Institute.

I have read and understand the information above, had the chance to ask questions, and agree to the evaluation and/or treatment described. I confirm that I have the legal authority to give this consent and understand I can ask my provider questions at any time. I also understand this consent meets the requirements of 42 CFR Part 2.

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Print Name of Patient DOB

_____ _____

Signature of Patient/Legal Guardian/Parent Date