Consent for Services and Communication

Psychiatric Services ● Email & Text

I, the undersigned, expressly consent to my (the patient's) medical treatment, including:

1. I authorize the healthcare professionals of Integrated Mentem Psychiatry and their designees and business associates, to administer medical tests, diagnostic procedures, and perform treatment, as well as view Sure Scripts, as considered medically or therapeutically necessary.

2. I understand that Mentem Psychiatry may share medical information with the health insurance company/companies I have identified as providing me with coverage, as may be necessary to process claims for medical services rendered to me.

3. I authorize payment of health insurance benefits to Integrated Mentem Psychiatry for medical services rendered to me.

4. I understand that more detailed information about my rights as a patient, and the way my medical information may be used or released, is described in Mentem Psychiatry Notice of Privacy Practices and that Mentem Psychiatry's Notice of Privacy Practices has been made available to me.

For psychiatric treatment, where applicable, I agree and understand that:

1. Treatment may include prescription and monitoring of psychotropic medications, lab monitoring, referral, psychoeducation, sleep hygiene, brief psychotherapy, and other necessary treatments.

2. I acknowledge Mentem Psychiatry cannot guarantee me specific results of psychiatric tests, treatments, or any other services rendered.

3. I understand my psychiatrist and/or pharmacist will provide me with information about known side-effects of any medication administered or prescribed.

4. I am aware there are exceptions to confidentiality of psychiatric records, as described in the Notice of Privacy Practices. These include but are not limited to:

- Mentem Psychiatry works as a team. My psychiatric provider may consult with another Mentem Psychiatry provider, a consulting psychiatrist, or a family practice provider to provide me with the best possible care.

- If I pose a threat of harm to myself and/or others, Mentem Psychiatry will take whatever steps are required or permitted by law to help prevent the harm from happening.

For phone, email, and text messaging I agree and understand that:

1. Mentem Psychiatry will use the contact information I have provided the office, including phone, address, and email address.

2. Mentem Psychiatry may leave detailed appointment, medical care, test results, and billing information on voicemails at the phone number I provide so long as the voicemail identifies me as the owner. Detailed messages will not be left on unidentified devices.

3. For my security and convenience, Mentem Psychiatry offers to communicate with me via the patient portal, however, if I prefer Mentem Psychiatry use an alternate email address (e.g., my personal email account), additional steps on my end may be necessary to access and read any emails sent to such external accounts.

4. I also understand that:

- Mentem Psychiatry considers all patient medical information as confidential. However, email users should never consider electronic communications to be entirely private or secure.
- Mentem Psychiatry strongly recommends that email communications be sent from and received via my patient portal account.
- I should NOT use email for any emergency situation or when an immediate or urgent response is needed.

Further, I agree and understand that:

1. I may be contacted for additional information regarding my health care or insurance coverage by Mentem Psychiatry.

2. I am responsible for, and agree to pay, all charges that exceed or are not covered by my health insurance coverage.

3. I understand that if the charges remain unpaid, I will need to reconcile the charges in order to be able to continue receiving services.

4. I intend this consent to remain in effect, so long as I am a patient of Mentem Psychiatry. However, I understand I may withdraw this consent in writing.

5. My withdrawal will not be effective for actions already taken (or in the process of being taken) by Mentem Psychiatry.

6. If I am under age 18, my parent or legal representative must sign this form consenting to medical care on my behalf with the exception of the following types of healthcare that by Iowa law I am able to consent for myself:

- Emergency Care
- Contraceptive Services

- HIV/AIDS Care
- Sexually Transmitted Infection prevention, diagnosis & treatment
- Substance Abuse Treatment
- Tobacco Cessation
- Victim Medical and Mental Health Services

Terms of Acceptance and Signature: I accept and understand that by typing my name here, I am signing this Agreement electronically. I agree and understand that my electronic signature is the legal equivalent of my handwritten signature and that I am legally bound by the terms contained in this document.

BY SIGNING THIS I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE POLICIES ABOVE

Patient Printed Name_____

Patient Signature_____

Signature of Legal Representative (if patient under age 18) and Relation to Patient (e.g., Mother, Father, Guardian, etc.) _____

Date_____