integrative minds™

Consent to Treat

1. I _____ (patient name) give permission for **Integrative Minds, PLC** to give mental health medical treatment.
    a. If filling out as a parent and/or legal guardian:
        - I _____ (parent/guardian name) give permission for **Integrative Minds, PLC** to give mental health medical treatment to _____ (patient name.)

2. I allow **Integrative Minds, PLC** to file for insurance benefits to pay for the care I receive.

    I understand that:
    - **Integrative Minds, PLC** will have to send my medical record information to my insurance company.
    - I must pay my share of the costs.
    - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
    - I have the right to refuse any procedure or treatment.
    - I have the right to discuss all medical treatments with my clinician.

4. If I have received care or treatment from another clinic or healthcare professional, I consent that my records from such clinic or healthcare professional be provided to Integrative Minds, PLC at their request.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature (for children under 18) Date

_____

Print name