Fortis Behavioral Health
220 Wintergreen Dr., Suite B
Lumberton, NC 28358
910-536-1719
910-668-8048

Informed Consent to Treatment

At my own discretion I am requesting treatment at Fortis Behavioral Health. I hereby give my consent to the rendering of counseling, psychotherapy, psychological assessment, psychiatric care, and medication management by Deana H. Flynn, MSN, PMHNP-BC, as may, in her professional judgment be necessary.

☐ I give my consent

Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. The client/patient may feel emotionally or physically distressed. These frustrations and discomforts may be lessened, and clients/patients may have a better positive outlook in managing his or her emotions or conditions. There is no firm timeline for this progress. Treatment/therapy's success shall depend both on the efforts of the provider and the client/patient.

☐ I understand

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my condition. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. I will be educated to the benefits and potential side effects or reactions that may result from any prescribed medication. I am aware that I have the right to request a copy of Stahl's prescribers guide for my use. This guide contains detailed information about prescription medications, adverse effects, and appropriate warnings. I have the right to ask questions regarding my treatment and expect that my questions will be answered to my full satisfaction. If I do withdraw from treatment, I have the right to have a referral to another practitioner for alternative treatment.

☐ I understand

I understand and will expect that all papers and documents concerning my treatment at Fortis Behavioral Health will be kept confidential. No information concerning my treatment can be released without my specific written consent except as required by law or in a situation deemed potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others, or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

☐ I understand

I agree to allow Fortis Behavioral Health to make this document a permanent part of my patient record.

☐ I agree

This consent can be revoked at any time by written notification provided to Fortis Behavioral Health in person or via the patient portal.

☐ I understand

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during this period.

☐ Yes

I have read this form and certify that I understand its contents.

☐ Yes

I hereby give my consent for treatment to Deana H. Flynn.

Patient Signature:_____

Date:_____

Name of SIGNER:_____

Relationship to patient is not signed by the patient:_____