Consent to Psychiatric Treatment by Frontier Psychiatry, LLC

I am signing this consent for psychiatric assessment and treatment on behalf of…

❑ **MYSELF** ❑ **A MINOR** ❑ **A DEPENDENT ADULT**

1. Benefits of Psychiatric Treatment
    a. Frontier Psychiatry will provide me with a psychiatric assessment, diagnosis and treatment services that, at a minimum, meet Montana's standard of care;
    b. When indicated, Frontier Psychiatry providers may provide both psychotherapy (aka "talk therapy") and medication management services;
    c. When possible, Frontier Psychiatry providers will coordinate psychiatric care with my community based counselor or therapist;
    d. Frontier Psychiatry providers may refer me to other medical, behavioral, or allied health professionals as needed to support an approach to holistic and comprehensive care.
2. Risks of Psychiatric Treatment
    a. Medications or supplements that have been prescribed or recommended by Frontier Psychiatry may cause physical or behavioral side effects;
    b. Engaging in psychotherapy may involve discussing unpleasant aspects of my life and can, at times, cause feelings of distress (eg. guilt, anxiety, frustration). While these experiences are generally temporary, it is extremely important that I describe them to my psychiatric provider.
3. Alternatives to Psychiatric Treatment
    a. I have the freedom to accept or reject treatment recommendations made by Frontier Psychiatry;
    b. I have the option to seek a second opinion regarding the diagnostic and treatment recommendations made by Frontier Psychiatry;
    c. I may end the treatment relationship with Frontier Psychiatry at any time.
4. Communication with Frontier Psychiatry
    a. Frontier Psychiatry will attempt to be available for urgent issues by phone; however, in the case of an emergency, I will call 911 immediately. I also know that I can reach the National Suicide Prevention Hotline at 1-800-273-8255 or I can reach the Crisis Text Line at 741-741.
    b. I understand that email should never be used for urgent or emergency issues. It is not a confidential means of communication and the email messages may not be received or answered in a timely fashion.
5. Payment
    a. Frontier Psychiatry is enrolled with several major public and private insurers in Montana. I am responsible for payment if my insurance policy has lapsed or I have neglected to keep the policy current. I am also responsible for any co-pays associated with treatment;

b. I hereby assign any of my health insurance benefits to be paid directly to Frontier Psychiatry;
c. Please find the self-pay rates - $400 for a New Patient Appointment, $200 for an Established Patient Appointment;
d. I understand that if I no-show my appointment I will be charged $25;
e. I understand that if my insurance is out-of-network and not accepted by Frontier Psychiatry that I will be considered self pay.

6. No Show Policy
    a. 1st no show - waived;
    b. 2nd no show - $25 dollar fee;
    c. 3rd no show - no further patient appointments will be scheduled.
7. Secure Telehealth Services
    a. I consent to receive the services described above via telehealth, as may be necessary or appropriate under the circumstances;
    b. Telehealth involves the use of electronic communications, such as real time audio, video, and data communications, to enable health care providers at different locations to share an individual's health information to diagnose, consult and/or treat the individual. Electronic communications used for telehealth incorporate network and software security protocols to protect the privacy and security of patient health information.
    c. As with any health care service, there are expected benefits and possible risks involving the use of telehealth. The expected benefits associated with the use of telehealth include, without limitation, improved access to health care and the ability to obtain the expertise of providers and specialists not readily available in the geographic area.
    d. Possible risks associated with telehealth include: potential delays in evaluation or treatment due to technical difficulties with equipment; information being transmitted in insufficient form to allow for a complete medical examination by the distant site practitioner; information may be lost during transmission due to technical failures; and despite security protocols being in place, the privacy of patient health information may be compromised when transmitted electronically.
    e. I have the right to withhold or withdraw my consent to the use of telehealth without affecting my right to future care or treatment. By signing in the space below, I consent to receive services via telehealth.

Name of patient (print):
Name of legal guardian (print): **Only if patient is under 18 or a dependent adult*

Signature of patient and guardian:	Date: