Informed Consent to Treatment & Mandatory Disclosure

1. This form is called an “Informed Consent Form.” As your mental health care provider, it is my obligation to provide you with the information you need in order to decide whether to consent to the treatment that I have recommended. The purpose of this form is to verify that you have received this information and have given your consent to the treatment recommended to you. You should read this form carefully and ask questions so that you understand the treatment before you decide whether or not to give your consent. If you have questions, you are encouraged and expected to ask them before you sign this form. <u>If you are under [STATE'S AGE OF CONSENT], your parent/legal guardian must consent to your treatment and sign this form.</u>

2. As your provider, I recommended the following treatment: ________________________________

   ____

   Upon your authorization and consent, this treatment will be performed for you by me, your provider, [PRINTED NAME, CREDENTIALS, LICENSE NUMBER, STATE]

3. All treatment carries the risk of unsuccessful results, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of:

   - The nature of the treatment, including other care, treatment or medications available to you;
   - Potential benefits, risks or side effects of the treatment;
   - The likelihood of achieving treatment goals; and
   - Reasonable alternatives and the relevant risks, benefits and side effects, if any, related to such alternatives, including the possible results of not receiving care or treatment

Except in cases of emergency, a new treatment approach (e.g., new therapy form) will not be performed until you have had the opportunity to receive this information and have given your consent. You have the right to give or refuse consent to any proposed treatment at any time prior to its performance.

4. We have discussed the risks and benefits of the current recommended treatment, including the following:
   a. The nature of the treatment: ____

      ____
   b. The expected benefits or effects of the treatment:__________________________________

      ____

      The possible risks and/or complications of the treatment, but are not limited to: ______

      ____
   c. *(If applicable)* Due to the following specific medical condition(s): _________________ ____, additional risks and/or complications of the treatment include, but are not limited to: _______________________

____

d. Alternative methods of treatment, including the nature of such treatments, their expected benefits or effects, and their possible risks and complications include: _____
____

e. Anticipated duration and cost/fee structure of treatment (or if you are a SonderMind client, you have reviewed SonderMind's Terms of Service): ____________________
____

f. Other issues discussed with the patient: ___________________________________
____

6. If you are receiving teletherapy services, synchronous or asynchronous, we discussed the risks associated with teletherapy including, but not limited to, security breaches, technical failures, delays in response, and the limitations of therapy via electronic means. We also discussed that

7. You have the right to discontinue treatment at any time and for any reason. Similarly, your provider also has the right to discontinue your treatment, but will provide you with at least 30 days' advance written notice of such discontinuation, and may assist you in finding a new treatment provider.

8. If you have any concerns or complaints about your treatment, you may direct them to [STATE REGULATORY BOARD/ADDRESS]. In professional relationships like patient/client-therapist, sexual intimacy is never appropriate and should be reported to [STATE LICENSING BOARD] and SonderMind.

9. Your signature on this form indicates that:
   - You understand that some health insurance carriers may not provide coverage for psychotherapy or other mental health services provided through telehealth technologies;
   - You have and understand the information provided in this form;
   - I adequately explained to you the treatment set forth above, along with the risks, benefits, and the other information described above in this form;
   - You had a chance to ask questions;
   - You received all of the information you desire concerning the treatment; and
   - You authorize and consent to the performance of the treatment.

Date: ______________________ Patient Age: _______ Patient DOB: __________________

Signature: ____

(patient/legal representative)

If signed by someone other than patient, indicate relationship: __________________________

Print name: ____

(legal representative)

**Disclaimer: This document is intended for educational purposes only. Please check with your legal counsel or state licensing board for specific requirements.