Shanti Wellness, LLC

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Consent for Evaluation and Treatment

Patient Name: _____ Date of Birth: _____

1) Consent to Evaluate/Treat: I voluntarily consent that I and my child/adolescent will participate in a psychiatric evaluation by Shanti Wellness, LLC. I understand that following the evaluation and/or treatment, information will be provided concerning each of the following areas:

a. The benefits of the proposed evaluation and treatment including diagnosis, recommendations for treatment, and education and support to the client and parents/guardians. Additional benefits would include possible improved cognitive or academic/job performance, social relationships, health status, quality of life, and awareness of strengths and limitations.

b. Alternative treatment modes and services, especially in the event that medication is not required or effective for the reported concerns.

c. The manner in which treatment will be administered

d. Expected side effects from the treatment, whether that is therapy or medications. If medication is recommended, a separate discussion involving informed consent for the medication will occur.

e. Probable consequences of not receiving treatment

2) The evaluation will be conducted by a Board-certified licensed child, adolescent, and adult psychiatrist. Treatment recommendations will follow the completion of the evaluation. This could take up to 2 sessions or more, if additional information is needed. My clinical information will be maintained in an electronic medical record that is compliant with privacy regulations.

3) Limits to Confidentiality: Information from this evaluation and/or treatment is contained in a confidential electronic medical record. I understand that confidential information may be released without my or my child/adolescent's consent in the event of the following circumstances since these are circumstances in which Shanti Wellness is required by law to disclose information for someone's protection:

a. suspected child abuse or neglect,
b. elder abuse or neglect,
c. domestic violence, or
d. any threats of risk of harming myself or threats of harming others.

I understand that there may be steps taken when a client is at risk of harming themselves or at risk of harming others. These steps might include calling 911, asking that the client go directly to the emergency room, calling police, and/or calling the potential victim in the event of a client stating they want to harm someone else. The steps discussed here are not fully inclusive, and other steps may need to be taken.

As a child or adolescent, I also understand that if there are any other issues that put my health/safety at risk, then my parent(s)/guardian may be notified during the session or at a future session based on clinical judgment.

4) Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

5) I understand that I have the right to ask questions of my service provider about the above information at any time.

Your signature below indicates that you have read the entire Shanti Wellness Evaluation and Treatment Consent Form. By signing below, you confirm that you understand the above and have had an opportunity to ask questions about this information. Your signature indicates that you are consenting to the psychiatric evaluation and treatment by Shanti Wellness, LLC.

As a parent/guardian, your signature also indicates that you attest that you have the legal right to consent for this evaluation and treatment and that there are no other parties who have similar rights and might disagree with this evaluation or treatment.

Name of patient (print):_____
Signature of patient: _____ Date: _____

Name of parent/guardian (print):_____
Signature of parent/guardian: _____ Date: _____

Name of clinician (print): Sonali Mahajan, MD
Signature of clinician: _____Date: _____