Harmonious Mind, LLC

5189 W Woodmill Dr, Wilmington, DE 19808 Tel:(302)633-6001 Fax:(302)295-6289

NEW PATIENT CONSENT FOR TREATMENT

Patient Name: ____ DOB: __________

Guardian Name: (If the Pt is under 18) ____

I, __________________________, hereby give consent to Harmonious Mind LLC for the following:	[Initials]
I confirm that I have the legal right to give this consent.	[____]
Psychiatric Evaluation & Treatment	[____]
I acknowledge the receipt of and agree to Practice Polices (available online).	[____]
I agree to respond to all requests for follow-up information I receive from Harmonious Mind LLC.	[____]
I acknowledge the receipt of the Tele-Psychiatry Policy and give consent for the same.	[____]
I give permission to use text and email service for communication.	[____]

Name / Address.: ____

____

Signature: ____Date: ___________

Witness Name / Signature____Date____________

Do you have or have had: ___Psycho-Therapist ___Psychiatrist __Neurologist __School __Supporting Family Member?

<u>CONTINUE ON THE SECOND PAGE *for* CONSENT FOR RELEASE OF INFORMATION</u>

CONSENT FOR RELEASE OF INFORMATION

I authorize Harmonious Mind LLC to: ___ RELEASE TO: ___ OBTAIN FROM:
The following agency, program, person:

____
____
____

The following information: __ All Records | __ Medication History | __ Labs | __ All Clinical Info including past & current symptoms & treatments | __ Psycho-social History |__ Substance Abuse History | __ Other as

____

PURPOSE OF OBTAINING / RELEASING INFORMATION: TREATMENT
Executed on: ________________Expires Three Months after Discharge

Printed Name & Signature of Client or Parent or Guardian or Authorized Representative:

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NOTE: Treatment is not conditioned by having to sign this consent. This information has been disclosed to the above-named recipient from records protected under Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR parts 160 & 164. The information specified above will be disclosed pursuant to this authorization, and the recipient of the information may re-disclose the information, which may no longer be protected by the HIPAA privacy law. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. To revoke this consent, the request must be done in writing to: Support Staff or your therapist at Woodmill Corporate Center, Suite 30, Wilmington, DE 19808. If not previously revoked, this consent expires on date recorded below.