CLEARCONNECT HEALTH SERVICES LLC

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Comprehensive Informed Consent for Psychiatric Assessment and Treatment

(In-Person and Telehealth Services)
Effective Date: April 18, 2026

Full Name:

____

Date of Birth:

____

I. CONSENT FOR PSYCHIATRIC SERVICES

I voluntarily consent to psychiatric evaluation, diagnosis, medication management, psychotherapy, and related behavioral health services (“Behavioral Care”).

I understand:

- Psychiatry involves clinical judgment based on available information.
- Outcomes cannot be guaranteed.
- Treatment plans may change as new information emerges.
- I may withdraw consent in writing at any time, except where action has already been taken in reliance upon my consent.

II. RISKS, BENEFITS, AND ALTERNATIVES

Potential benefits include symptom reduction, improved functioning, and enhanced quality of life.

Risks may include:

- Medication side effects or adverse reactions
- Emotional distress during therapy
- Worsening of symptoms
- Failure to improve
- Rare but serious complications

Alternatives include:

- No treatment
- Referral to another provider
- Higher level of care
- In-person instead of telehealth services

I understand that declining recommended treatment may increase risk of symptom persistence or worsening.

III. SUICIDE RISK AND SAFETY EXPECTATIONS

I understand:

- Suicide risk assessment cannot predict behavior with certainty.
- Risk levels may fluctuate over time.
- Immediate disclosure of suicidal thoughts is critical for safety.

If I experience crisis-level symptoms, I agree to:

- Contact 911 or go to the nearest emergency room.
- Call 988 (Suicide & Crisis Lifeline).
- Inform my provider as soon as possible.

If my provider determines there is imminent risk of serious harm, emergency services or my emergency contact may be notified without additional consent as permitted by law.

If I decline a recommended higher level of care (e.g., hospitalization), I acknowledge:

- The risks of refusal have been explained.
- Refusal will be documented.
- Involuntary evaluation procedures may be initiated if legally required.
- If required under Virginia law, emergency custody or temporary detention procedures may be initiated to protect safety.

IV. MEDICATION ADHERENCE AND CONTROLLED SUBSTANCE SAFEGUARDS

If prescribed psychiatric medications, including controlled substances:

- I agree to take medication only as prescribed.
- I will not abruptly discontinue medication without medical guidance.
- Monitoring (including labs or PDMP review) may be required.
- Early refills or replacement of lost medication may be declined.
- Urine drug screening or pill counts may be required when clinically indicated.

Prescriptions for controlled substances may be limited in quantity and require regular follow-up visits. ClearConnect may decline to prescribe or may discontinue controlled medications if safety concerns arise.

Failure to comply with safety requirements may result in medication modification or discontinuation.

V. TELEHEALTH CONSENT

Telehealth involves secure electronic communication.

I understand:

- Telehealth may limit physical examination capabilities.
- Technical failures may occur.
- I must provide my physical location at each session.
- I must provide an emergency contact.
- Telehealth is not appropriate for life-threatening emergencies.

If acute safety concerns arise, emergency services may be contacted.

Sessions will not be recorded without written authorization. I agree not to record sessions without provider knowledge and consent.

VI. LIMITS OF CONFIDENTIALITY

My health information is protected under HIPAA and Virginia law.

Confidentiality may be limited if:

- There is a serious and imminent threat of harm.
- Abuse or neglect is suspected.
- Disclosure is required by court order or law.
- Disclosure is permitted for treatment, payment, or healthcare operations.
- Suspected child abuse, elder abuse, or abuse of a vulnerable adult.

Only the minimum necessary information will be disclosed when possible.

VII. PATIENT ACCESS RIGHTS (HIPAA)

I understand that I have the following rights:

Right to Access:

- I may inspect and obtain a copy of my medical records.
- Requests must be in writing.
- We will respond within 30 days.
- Records may be provided in electronic format if available.
- Reasonable cost-based fees may apply.

Right to Amend:

- I may request correction of inaccurate or incomplete information.
- Requests must be in writing and include a reason.
- If denied, I may submit a written disagreement.

Right to Accounting of Disclosures:

- I may request a list of certain disclosures made within the past six years (excluding treatment, payment, and operations).

Right to Request Restrictions:

- I may request limits on certain disclosures.
- If I pay in full out-of-pocket and request in writing that information not be disclosed to my health plan, that request will be honored unless required by law.

Right to Confidential Communications:

- I may request communication at a specific location or by specific method.

Right to Breach Notification:

- I will be notified if my unsecured protected health information is breached as required by law.

Right to Receive Notice of Privacy Practices:

- A copy is available at:
- https://clearconnectmh.com/forms/
- I may request a paper copy at any time.

VIII. MINOR CONSENT (VIRGINIA LAW)

If the patient is under 18 years old:

- A parent or legal guardian generally must consent.
- Virginia law allows minors to consent independently to certain mental health services.
- Confidentiality for minors may be protected to the extent permitted by law.
- Safety-related disclosures may still occur.

IX. CAPACITY AND DECISION-MAKING

If at any time I lack decision-making capacity:

- A legally authorized representative may make decisions.
- Emergency treatment may occur as permitted by law.
- Records are maintained and retained in accordance with applicable Virginia and federal law.

X. FINANCIAL RESPONSIBILITY

I authorize ClearConnect to bill my insurance.

I understand:

- I am responsible for deductibles, copays, coinsurance, and non-covered services.
- I may request a Good Faith Estimate if uninsured or self-pay.
- Insurance authorization requirements remain my responsibility.

Failure of insurance payment does not eliminate financial responsibility.

XI. AI-ASSISTED DOCUMENTATION

Secure AI-assisted documentation tools may be used to support note-taking.

Appropriate safeguards are in place to protect confidentiality.

I may withdraw consent for AI-assisted documentation in writing.

XII. NO GUARANTEE OF OUTCOME

I understand that:

- Psychiatric care involves uncertainty.
- Improvement is not guaranteed.
- Adverse outcomes may occur despite appropriate care.

XIII. TERMINATION OF TREATMENT

- ClearConnect Health Services LLC reserves the right to terminate the treatment relationship in non-emergency situations for reasons including, but not limited to: repeated missed appointments, non-adherence to treatment recommendations, unsafe or threatening behavior, diversion or misuse of prescribed medications, failure to maintain payment arrangements, or breakdown of the therapeutic relationship. Except in situations involving safety concerns or legal requirements, reasonable notice will be provided when possible. Referrals to alternative providers may be offered when clinically appropriate. Termination does not apply in emergencies, and emergency care should be sought by calling 911 or going to the nearest emergency room.

XIV. ACKNOWLEDGMENT

By signing below, I confirm that:

- I have read and understand this document.
- I have had the opportunity to ask questions.
- I voluntarily consent to psychiatric assessment and treatment.

Emergency Contact Name & Phone (Required for Telehealth):

____

Preferred Pharmacy:

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Please sign your name below *

Signature	Date

☐ I am the parent/guardian of this patient