MOSAIC MIND PSYCHIATRY
Informed Consent to Treatment Form

At my own discretion I am voluntarily consenting to and requesting treatment with Mosaic Mind Psychiatry. I know that my treatment may consist of pharmacotherapy, psychotherapy or a combination of both. I acknowledge that the nature and purpose of the proposed psychiatric evaluation and treatment have been explained to me in terms that I understand. I have been informed of the reasons for the proposed treatment, as well as the potential risks, benefits, and possible alternatives. I have had the opportunity to ask questions and have received answers to my satisfaction. I understand that the practice of medicine and surgery is not an exact science and that the results cannot always be anticipated. I acknowledge that no guarantees have been made to me as a result of examination, procedures or treatment in this office. I have been given the chance to withdraw from treatment and am aware that I have the right to a referral to another practitioner for alternative treatment. Based on this information, I voluntarily consent to receive psychiatric evaluation and treatment.

I agree to allow Mosaic Mind Psychiatry to make this document a permanent part of my patient record.

In regards to telemedicine, I voluntarily consent to receive medical evaluation, treatment, and follow-up via telehealth. I understand the risks, benefits, and limitations of virtual care and may withdraw consent at any time. I attest that I am physically located within the state of Pennsylvania (PA) or New Jersey (NJ) at the time of my telehealth appointment. I understand that providing false information about my location may affect the provider's ability to legally deliver care. I understand that it is my responsibility to verify whether my health insurance plan provides coverage for telehealth or virtual appointments. The practice cannot guarantee insurance coverage or reimbursement due to variations in insurance plans, policies, and changing insurance regulations. If my insurance does not cover telehealth services, denies the claim, or applies charges toward my deductible, coinsurance, or copay, I agree to be fully financially responsible for any fees associated with my telehealth visit.

Finally, I understand and will expect that all papers and documents concerning my treatment at Mosaic Mind Psychiatry will be kept confidential. No information concerning my treatment can be released without my specific written consent except as required by law or in a situation deemed potentially life-threatening. According to Federal Regulations, licensed providers are mandated to report information that professional judgment would determine constitutes threat or serious harm to self or others, or indicates child or elder abuse or neglect. You have my consent, without reservation, to release any such information about me without further written approval.

Patient Name (printed)

Signature of Patient or Legal Guardian Date Signed