I CARE PSYCH (DBA)

CONSENT TO TREATMENT & DISCLOSURE OF INFORMATION

As the patient or legal guardian with the authority to consent on behalf of the patient named below (collectively hereinafter referred to as the "Patient"), I hereby consent for the Patient to receive medical treatment At I Care Psych, LLC, which may include services provided by employed and/or contracted providers (collectively "Comprehensive Addiction and Recovery Epicenter Management"). My signature below hereby confirms my consent for the I Care Psych LLC to provide health care services and prescribe/administer medicinal drugs to the Patient as described herein. This consent includes, without limitation, consent for the Patient to be evaluated, diagnosed, and treated for medical conditions (including physical, mental health conditions, substance use disorders, or other sensitive conditions if applicable to the Patient), as deemed necessary and advisable in the judgment of the Patient's treating providers.

TREATMENT SERVICES. I understand that the rendering of medical care is not an exact science and no guarantees have been given to me by anyone as to the results or outcomes that may be obtained from examinations, treatments, medications, therapy, or other healthcare services provided or recommended by I Care Psych LLC. Treatment services provided to the Patient may consist of the following outpatient services, without limitation and where applicable to the Patient: ordinary and necessary medical and psychiatric treatment and examinations consisting of physical exams, counseling, psychotherapy, psychiatric care, mental health evaluations, psychological assessments, medication assisted treatment and substance use disorder treatment. I understand and agree that this may include the administration and/or prescribing of medications, potentially including controlled substances and psychotropic medications, used in the course of ordinary and necessary medical, substance use disorder, and psychiatric care. I acknowledge that I have the right to refuse any and all treatment services and medications. All treatment services provided by I Care Psych LLC are on an outpatient basis only. I understand that I Care Psych LLC is not an emergency response unit or inpatient facility. By signing below, I agree to call 911 or go immediately to an emergency room for any emergency medical event or a situation that could reasonably be expected to develop into an emergency.

MEDICATIONS. I agree to inform my treating providers of medications taken and/or prescribed to the Patient. Medications should be used only as directed. All medications have side effects. If the Patient experiences side effects or any unusual feelings as a result of medication prescribed during the course of treatment, I agree to contact the office and inform the Patient's provider. If the concern is severe enough, is an emergency, or is a situation that could possibly develop into an emergency, I agree to immediately dial 911 or go to the nearest emergency room and follow the directions of emergency personnel. I understand that alternative treatments may be available that do not involve medications. I agree to ask my provider if I have any questions related to alternative treatments, the risks associated with not treating a problem or condition, as well as the risks involved in any specific medication.

CONSENT TO OFF-LABEL USE. Once a medication is approved by the U.S. Food and Drug Administration ("FDA"), the manufacturer produces a "label" to explain its use. Health care providers may use or recommend such medication for other purposes (referred to as "off-label") if the health care provider is well-informed about the medication, base its use on firm scientific method and sound medical evidence, and maintain records of its use and effects. Medications recommended during the course of treatment at I Care Psych LLC may be for a use that is not specified in the FDA approved labeling. By signing below,

I acknowledge my understanding that medications recommended to the Patient during the course of treatment may be prescribed for a use that is not specified in the FDA approved labeling for which it is being used, but rather, may be recommended for an off-label use based on the professional judgment of the treating provider. I acknowledge that the risks associated with medications prescribed and any off-label use have been explained and agree to address any concerns I have about off-label medication use with the Patient's provider.

CONFIDENTIALITY. I Care Psych LLC is dedicated to maintaining the privacy of health and other sensitive information in accordance with applicable law. Patient information, including any substance use disorder diagnosis or treatment information if applicable, will be held confidential in accordance with applicable law unless a legal exception applies, or I consent to the disclosure. For any such disclosures, I Care Psych LLC will limit the information disclosed to that which is necessary to carry out the purpose of the disclosure. Generally, I Care Psych LLC will not acknowledge that the Patient is a patient without consent or a valid court order. More details about how patient information may be used or disclosed is included in the Notice of Privacy Practices. By signing below, I confirm that I received a copy of the I Care Psych LLC Notice of Privacy Practices and understand that I can request more information about my privacy rights at any time.

DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. I specifically authorize I Care Psych LLC to obtain, use, and/or disclose the Patient's health information as necessary to provide treatment to the Patient, process and receive payments related to the Patient's treatment, and for health care operations in accordance with applicable law. This specifically includes authorization to disclose the Patient's health information, including without limitation complete psychological and assessment records, treatment plans, progress summaries, treatment notes, diagnosis, mental health information, HIV/AIDS and/or other STD information, substance use diagnosis and treatment information, genetic information, and related documents and information to outside health care providers providing treatment services to the Patient, health insurance companies, and business associates for the purposes of treatment, payment, and health care operations. I understand that I may revoke this consent to disclose the Patient's information at any time except to the extent I Care Psych LLC has acted in reliance on it.

DISCLOSURE TO PRESCRIPTION DRUG MONITORING PROGRAM. The State of Florida has a prescription drug monitoring program ("PDMP") in place to monitor the prescribing and dispensing of controlled medications. In accordance with Florida law, where applicable, I consent to I Care Psych LLC providers accessing and/or disclosing health information, including substance use information, for the purpose of accessing and maintaining the PDMP database and providing treatment services to the Patient (including coordination of care).

ASSIGNMENT OF BENEFITS. I hereby authorize direct payment of medical benefits to I Care Psych LLC for services rendered by I Care Psych LLC and its providers. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized benefits be made on my behalf to I Care Psych LLC and authorize the use and disclosure of the Patient's health information (including mental health information and diagnosis, HIV/AIDS and/or other STD information, substance use diagnosis and treatment information, and genetic information) as needed to facilitate payment for the services provided.

I further acknowledge that:

- I Care Psych LLC will be required to send the Patient's medical information to my insurance company when services are billed to insurance.
- I have the right to refuse any procedure or treatment and to discuss all medical treatments with my provider.
- I agree to call 911 or go immediately to an emergency room if the Patient is having an emergency medical event or a situation that could reasonably be expected to develop into an emergency.

I CONFIRM I HAVE REVIEWED THE ABOVE, HAD AN OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED, AND THAT I AM VOLUNTARILY CONSENTING TO SERVICES TO BE RENDERED TO THE PATIENT BY I CARE PSYCH LLC AND ITS PROVIDERS.

This document is effective until the later of one year from the date of signature below or the conclusion of treatment services.