Indy Behavioral Health, LLC
2629 Waterfront Parkway East Drive, Suite 108
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

Consent to Treatment

Patient Name: ____

DOB: ___________________________________

Date: ___________________________________

I voluntarily consent to outpatient care with Sonya Ruedlinger, NP

- I understand Sonya Ruedlinger, NP uses an integrative psychiatry and mental health approach with limited use of medications.

- I understand that the care I receive from Sonya Ruedlinger, NP may be considered non-conventional. Such services are commonly referred to as integrative, complementary, alternative or holistic services. This can include nutritional and supplement recommendations, mindfulness and breathing practices, and other mind-body approaches to care. While many of these techniques have been long practiced and researched and found to be effective, many are still considered "investigative" or "experimental". The treatment plan is a collaborative effort and I recognize it is my responsibility to let Sonya know which approaches I would like to try and those with which I do not feel comfortable. I recognize it is entirely my choice. By accepting these treatments I agree to accept the risks explained to me about these treatments.

I have read and understand the foregoing and understand that it is my responsibility to discuss any concerns I have about any and all parts of my treatment plan. I understand the nature of these health care methods and consent to counseling and treatment.

Patient Name: ____

Patient Signature: ____

Signature of Guardian if Patient is under 18:____

Date: _______________________________

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CONFIDENTIALITY: All information between provider and patient is held strictly confidential unless.

1) The patient authorizes release of information with a signature;

2) The provider is ordered by a court to release information;

3) The patient presents a physical danger to self or others;

4) Child abuse/neglect is suspected. In the two latter cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

I have read the foregoing, understand its content, and agree to the conditions stipulated herein.

Patient Name: ____

Patient Signature: ____

Signature of Guardian if Patient is under 18:____

Date: ________________________________