UnityPoint Health
Des Moines

I,_____, understand that I may have a condition requiring psychiatric, medical, behavioral, and/or mental health diagnosis and treatment. I request and consent to all nursing services, x-ray and diagnostic procedures, laboratory tests and other professional services which may be provided as part of the treatment recommended by the attending physician(s) or other physicians on the Medical Staff of the Hospital.

I am aware that the practice of medicine and psychiatry is not an exact science, and I acknowledge that no guarantees have been made as to the result of examination or treatment.

I understand that the Hospital and its personnel may take certain actions to protect me, other patients, or other persons in the Hospital against possible harm from such things as alcohol, medication, illegal drugs, or dangerous instruments, therefore I authorize the Hospital to take necessary action, including a search of my belongings or my person in an effort to protect me or others from possible harm. I also understand that there are rules of behavior for participation in this treatment program and that compliance with these rules is necessary for my continued participation in this treatment program. Knowing this, I agree to terminate my participation in this treatment program and leave the Hospital immediately upon oral or written notice from the Hospital of any noncompliance, by me, of the program rules. Further, I understand that if my behavior warrants the need for restraint, that I will be removed from the treatment program setting and taken to the Hospital Emergency Department for further evaluation.

I authorize the disclosure of medical information from services provided pursuant to this consent for treatment to Hospital staff and employees, as appropriate, and all health care professionals involved in my care, to facilitate the provision of administrative and professional services to me. I further authorize the Hospital to release health information related to this admission or course of treatment to my health insurance company, health plan, or other third party payor, or its authorized agents or representatives for the purpose of determining benefits payable in connection with the services provided by the Hospital. In the event that this course of treatment includes the diagnosis and/or treatment of mental health, substance abuse, or HIV/AIDS testing information, the medical records are subject to separate authorization and shall not be released pursuant to this authorization alone. No person or entity shall be liable for disclosing records in the good faith belief that disclosure is authorized by this release.

PATIENT LABEL

ILH CONSENT TO OUTPATIENT MENTAL HEALTH TREATMENT

I understand that the Hospital is not responsible for my personal property or my valuables and I release the Hospital from all responsibility for my personal possessions including money, jewelry, credit cards, glasses, dentures or other personal property which I may bring with me to the treatment program.

I HAVE READ THIS CONSENT AND I UNDERSTAND IT. I ACKNOWLEDGE THAT THE MATTERS CONTAINED HEREIN HAVE BEEN FULLY EXPLAINED TO ME AND ANY QUESTIONS I HAVE ASKED HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____

Date Patient's signature

_____

Witness

If the patient is a minor or lacks legal capacity, signature of person with legal authority to consent on behalf of the patient. If so, the relationship to the patient is:

_____ _____

Date Parent, guardian or person authorized to consent for patient

_____

Witness

PATIENT LABEL