

Informed consent to treatment at iMindU

This form documents that I,....., (the patient or legal guardian) give my consent and agreement to iMindU to provide multidisciplinary treatment to me and if applicable my family as indicated in the treatment plan. While I can expect benefits from this treatment, I fully understand that no particular outcome can be guaranteed. I understand that I am free to discontinue treatment at any moment, but that it would be best to discuss with the therapist, doctor, or multidisciplinary team any plans to end therapy before doing so. I have discussed with the therapist or doctor what is involved in my multidisciplinary treatment and understand and agree to the policies about scheduling, fees, and missed appointments as mentioned on the iMindU website and in the iMindU general and billing conditions. The discussion about therapy has included explanation about the doctor or therapists' evaluation and diagnostic formulation, any additional diagnostics, the proposed method of treatment, treatment goals and expected length of treatment, evaluation moments, information about medication effects and side-effects, working mechanism, pharmacokinetics, alternative medication, routine outcome monitoring or repeat diagnostics, and information about record-keeping. I have been informed about and understand the extent of treatment, its foreseeable benefits and risks, and possible alternative methods of treatment. I understand that therapy can sometimes cause upsetting feelings to emerge, and that my problems may worsen temporarily before improving. The doctor or therapist has explained that the best chance to benefit from therapy is if patient and therapist are able to form a therapeutic alliance of trust, that is a worthwhile connection. In an effective therapeutic relationship, you will feel heard, valued, respected and comfortable or can at least discuss adverse feelings and where they come from.

The contact information you gave iMindU has been used to open a medical record file. All information is strictly confidential unless the therapist is legally obliged to provide information or if the patient or someone else is in direct danger.

The patient understands that he/she has the right to ask the doctor or therapist about the doctor's or therapist's training and qualifications and about where to file complaints about the therapist's professional conduct. All forms and procedures can be found on the iMindU website. By signing below I am indicating that I have read and understood this agreement, that I give consent to the doctor's or therapist's or multidisciplinary treatment.

Date:

Date:

Name patient:.....

Name therapist/doctor:.....

Signature:.....

Signature:.....