RESOLUTIONS
WELLNESS GROUP

Consent for Treatment

PATIENT IDENTIFICATION

Full Legal Name (Last, First, Mi):

_____

Date of Birth: _____ Chart#: _____ Date:_____

Consenting Party (if not patient): _____

Relationship : _____

Legal Basis for Surrogate Consent (if applicable):

____ Legal guardian ____ Healthcare proxy ____ Power of attorney — Documentation on file: ____Yes

SECTION 1: ABOUT RESOLUTIONS WELLNESS GROUP

Welcome to **Resolutions Wellness Group.** Our **mission** is to provide compassionate, evidence-based, integrated outpatient care to individuals living with **Substance Use Disorders (SUDs)** and co-occurring **psychiatric** conditions. We believe that **recovery is possible** for everyone, and we are committed to meeting you where you are — with dignity, respect, and hope. Our team operates **without** judgment, recognizing that addiction and mental health conditions are medical conditions deserving of the same quality care as any other health concern.

Resolutions Wellness Group operates in full compliance with the standards established by the **Substance Abuse and Mental Health Services Administration (SAMHSA), the American Society of Addiction Medicine (ASAM), the American Psychiatric Association (APA), and the Texas Health and Human Services Commission (HHSC).** Every treatment plan is individualized, stigma-free, and oriented toward sustainable, long-term recovery and mental wellness.

Services offered at this clinic (check all that apply to your current enrollment):

Medication-Assisted Treatment (MAT) / Medications for Opioid Use Disorder (MOUD) — buprenorphine, naltrexone, methadone referral Addiction medicine evaluation and management.

Psychiatric evaluation and diagnostic assessment Psychotropic medication management (antidepressants, mood stabilizers, anxiolytics, antipsychotics, stimulants) Individual psychotherapy / counseling (if provided on-site) Group therapy and psychoeducation Case management and care coordination Peer recovery support services Urine drug screening (UDS) monitoring Overdose prevention and naloxone distribution Other:_____

SECTION 2: CONSENT FOR ADDICTION TREATMENT SERVICES

2.1 – Nature of Addiction Treatment

Substance Use Disorder (SUD) is a chronic, progressive, and treatable medical condition formally recognized by the American Medical Association (AMA), the American Psychiatric Association (APA), and the American Society of Addiction Medicine (ASAM). It is characterized by compulsive substance use despite negative consequences, changes in brain structure and function, and significant impairment in daily functioning. Like other chronic medical conditions such as diabetes or hypertension, SUD responds to evidence-based treatment and ongoing disease management.

Treatment at Resolutions Wellness Group may include a comprehensive medical and psychosocial evaluation, individual and/or group counseling, behavioral therapies, Medication-Assisted Treatment (MAT), urine drug screening, and ongoing monitoring and adjustment of your individualized treatment plan. **Participation in treatment is entirely voluntary.** You retain the right to refuse or withdraw consent for any component of your treatment at any time, and you will be informed of the potential consequences of doing so.

2.2 – Consent for MAT / MOUD

Medications for Opioid Use Disorder (MOUD) are a first-line, evidence-based standard of care for opioid use disorder, endorsed by SAMHSA, ASAM, the AMA, and the APA. By initialing below, I confirm that I have been fully informed of and consent to the following:

- **MOUD** is an evidence-based treatment that may include buprenorphine (Suboxone, Sublocade), naltrexone (Revia, Vivitrol), or referral to a licensed methadone Opioid Treatment Program (OTP), as determined collaboratively with my provider.

- I have been informed of the risks, benefits, and alternatives to each medication option applicable to my care.
- **Buprenorphine** is a Schedule III controlled substance under federal law. It may cause physical dependence with regular use. Abrupt discontinuation may cause withdrawal symptoms. It is never appropriate to stop buprenorphine suddenly without guidance from a provider.
- **Naltrexone** is not a controlled substance and is not habit-forming. It works by blocking opioid receptors and reducing cravings. It does not cause dependence.
- **MOUD medications must be taken exactly** as prescribed and **must never be shared** with others. Sharing, selling, or diverting MOUD medications is a federal crime with serious legal consequences.
- **Urine drug screens (UDS)** will be conducted regularly as an established standard of clinical care — not as a punitive measure — to guide treatment decisions and ensure safety.
- **Participation** in behavioral health counseling is strongly recommended and may be required as a component of my individualized treatment plan.
- I have been **informed** about the risk of overdose if I use opioids while on MOUD, particularly if I have missed doses or if my tolerance has changed. Reduced tolerance significantly increases overdose risk.
- I have **received or been offered** naloxone (Narcan) and overdose prevention education as part of my care.
- **Applicable MOUD** — Check all that apply and initial:

		Initials	Date
	Buprenorphine/naloxone (Suboxone / generic sublingual film or tablet)		
	Buprenorphine mono (sublingual tablet — typically for pregnant patients)		
	Extended-release buprenorphine injectable (Sublocade)		
	Naltrexone oral (Revia)		
	Extended-release naltrexone injectable (Vivitrol)		
	Methadone (referral to licensed Opioid Treatment Program / OTP)		

2.3 – Risks of Addiction Treatment (General)

I **acknowledge** that I have been informed of the following possible risks associated with addiction treatment and MOUD. I have had the **opportunity** to ask questions:

- **Medication side effects** including but not limited to: nausea, constipation, headache, sleep disturbance, sweating, sexual dysfunction, and injection-site reactions (for injectable formulations).
- **Risk of precipitated withdrawal** with buprenorphine induction if I am not adequately withdrawn from short- or long-acting opioids prior to my first dose.
- **Risk of opioid overdose** with return to opioid use during naltrexone treatment due to reduced opioid tolerance.
- **Risk of drug-drug interactions**, particularly with central nervous system (CNS) depressants including benzodiazepines, alcohol, sedatives, sleep aids, and gabapentinoids (gabapentin, pregabalin).
- **Potential** for diversion-related **legal consequences** if controlled medications are misused, sold, or transferred.
- **QTc interval prolongation risk** with methadone — cardiac monitoring (EKG) is required.

⚠ FDA BLACK BOX WARNING

The concurrent use of opioids (including buprenorphine and methadone) with benzodiazepines or other central nervous system (CNS) depressants — including alcohol — significantly increases the risk of profound sedation, respiratory depression, coma, and death.

This risk will be discussed with you at initiation and at every clinical encounter.

2.4 – Alternatives to MAT

I have been informed of the following alternatives to Medication-Assisted Treatment:

- Abstinence-based treatment without medication (with clinical discussion of relative effectiveness).
- Inpatient or residential detoxification and rehabilitation programs.
- Intensive Outpatient Program (IOP) or Partial Hospitalization Program (PHP).
- Self-help and peer support programs (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, Refuge Recovery).
- No treatment — with a clear explanation of the associated risks, including increased risk of relapse, overdose, and death.

I understand that my provider recommends MOUD or addiction treatment services based on a clinical assessment of my individual needs and that I am free to discuss any of these alternatives at any time.

SECTION 3: CONSENT FOR PSYCHIATRIC EVALUATION AND MEDICATION MANAGEMENT

3.1 – Nature of Psychiatric Services

Resolutions Wellness Group **provides outpatient psychiatric** evaluation, diagnostic assessment, and psychotropic medication management for co-occurring mental health conditions. These may include, but are not limited to: Major Depressive Disorder, Bipolar Spectrum Disorders, Generalized Anxiety Disorder, Panic Disorder, Social Anxiety Disorder, Post-Traumatic Stress Disorder (PTSD), Attention-Deficit/Hyperactivity Disorder (ADHD), Psychotic Disorders, Obsessive-Compulsive Disorder (OCD), and other conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Psychiatric services at this clinic are integrated with addiction care to provide whole-person, simultaneous treatment for both conditions. Research consistently demonstrates that treating co-occurring disorders together — rather than sequentially — leads to better outcomes for both conditions. **Our team** is trained to understand how substance use and mental health conditions interact and influence one another.

3.2 – Consent for Psychiatric Evaluation

I **consent** to the following components of a comprehensive psychiatric evaluation:

- A thorough diagnostic interview including psychiatric history, medical history, family history, trauma history, developmental history, and social history.
- Mental status examination (MSE) at each encounter.
- Use of standardized validated rating scales and screening tools as clinically indicated, including: PHQ-9, GAD-7, PCL-5 (trauma), ASRS (ADHD), Columbia Suicide Severity Rating Scale (C-SSRS), AUDIT (alcohol), DAST-10 (drug use), MDQ (mood), and others.
- Review of relevant medical records and laboratory results.
- Coordination with prior treating providers, with appropriate written authorization.
- Collateral information gathering from family members, other providers, or agencies — only with appropriate signed consent or release of information on file.

3.3 – Consent for Psychotropic Medication Management

I **understand and consent** to the following regarding psychotropic medication management:

- My provider may recommend **psychotropic medications** to treat co-occurring psychiatric conditions. These may include **antidepressants** (SSRIs such as sertraline, escitalopram; SNRIs such as venlafaxine, duloxetine; bupropion; mirtazapine), **mood stabilizers** (lithium, valproate/valproic acid, lamotrigine), **antipsychotics** (aripiprazole, quetiapine, risperidone, olanzapine, lurasidone), **non-benzodiazepine anxiolytics** (buspirone, hydroxyzine, propranolol), sleep aids (trazodone, melatonin), or stimulants for ADHD.

- **Each medication** my provider recommends will be explained to me individually, including its intended purpose, expected timeline for effectiveness, common side effects, serious or rare side effects, and alternatives.
- **Stimulant medications** (amphetamine salts/Adderall, methylphenidate/Ritalin, lisdexamfetamine/Vyvanse, and others) are Schedule II controlled substances. They are prescribed with careful clinical judgment in the context of active or recent Substance Use Disorder and require a separate Controlled Substance Agreement if prescribed at this clinic.
- **Benzodiazepines** (alprazolam/Xanax, clonazepam/Klonopin, lorazepam/Ativan, diazepam/Valium) are generally avoided in patients with active or recent SUD due to significant misuse and dependence potential. If prescribed in exceptional circumstances, a specific Co-Prescribing Risk Acknowledgment is required (see Section 5 of this form).
- I **understand that psychiatric medications** may require several weeks to reach full therapeutic effectiveness and that dose adjustments may be needed.
- I **agree to report any** side effects, worsening symptoms, or new concerns to my provider promptly and not to wait until my next scheduled appointment if the concern is urgent.
- I **understand I should not stop** psychiatric medications abruptly without consulting my provider, as this may cause discontinuation syndrome, withdrawal, or relapse of psychiatric symptoms.
- **Pregnancy notice:** Some psychotropic medications carry risks during pregnancy or breastfeeding. I will notify my provider immediately if I am pregnant, become pregnant, or am breastfeeding, so that a risk-benefit discussion can occur and medications can be adjusted as needed.

3.4 – Risks of Psychiatric Treatment (General)

I **acknowledge being informed** of the following general risks associated with outpatient psychiatric treatment:

- **Side effects** of specific medications, communicated individually at the time of prescribing and updated at each encounter as clinically indicated.
- **Risk of psychiatric symptom** worsening during the initial treatment period before medications reach full effect.
- **Risk of antidepressant-induced** activation, agitation, or mood switching — particularly in individuals with unrecognized bipolar disorder (antidepressant monotherapy may trigger a hypomanic or manic episode).
- **Risk that mental health and substance** use conditions may interact with and complicate each other's treatment — a phenomenon our integrated care model is specifically designed to address
- **Risk of inadequate treatment** response requiring medication changes, dose adjustments, augmentation strategies, or referral to a higher level of care.
- **Risk of medication interactions**, particularly with MOUD and other concurrently prescribed medications.

3.5 – Alternatives to Psychiatric Medication

I have been **informed** of the following alternatives to psychotropic medication management:

- **Evidence-based psychotherapy alone** — including Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), Eye Movement Desensitization and Reprocessing (EMDR), Acceptance and Commitment Therapy (ACT), and others
- **Lifestyle** modification strategies including sleep hygiene, regular exercise, nutrition, mindfulness practices, and social support
- **Community mental health** resources, peer support specialists, and recovery coaching
- **Higher level** of psychiatric care including Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), or acute inpatient psychiatric hospitalization
- **No treatment** — with an explanation of the associated risks, including potential worsening of psychiatric symptoms and impact on recovery from SUD.

SECTION 4: LIMITS OF OUTPATIENT CARE AND HIGHER LEVEL OF CARE

Outpatient addiction medicine and psychiatric services are designed and appropriate for individuals with mild-to-moderate severity conditions who are medically stable and able to participate in scheduled outpatient appointments. Resolutions Wellness Group continuously monitors the clinical appropriateness of outpatient care for each patient and will recommend or facilitate a safe transfer to a higher level of care when clinically indicated using evidence-based ASAM and LOCUS criteria.

- Higher levels of care to which we may refer include: Intensive Outpatient Programs (IOP), Partial Hospitalization Programs (PHP), residential or inpatient substance use disorder treatment, medically supervised detoxification, and acute inpatient psychiatric hospitalization. Our team will collaborate with you on any such transition and will communicate with receiving providers to ensure continuity of care.

⚠ IMPORTANT — EMERGENCY AND CRISIS SERVICES

Resolutions Wellness Group **does not provide** 24-hour emergency or crisis services.

If you are experiencing a psychiatric emergency, a medical emergency, or are in immediate danger of harming yourself or others, please call **911** or go to your nearest **emergency room** immediately.

Crisis resources are listed in **Section 8** of this form. Please carry this information with you.

SECTION 5: BENZODIAZEPINE CO-PRESCRIBING RISK ACKNOWLEDGMENT

(Complete this section ONLY if benzodiazepines are prescribed concurrently with MOUD or other opioids. If not applicable, check the box below and leave the remainder of this section blank.)

☐ Not applicable — benzodiazepines are not being co-prescribed at this time ☐ Applicable — complete the acknowledgment below

I _____ understand and acknowledge the following:

- The concurrent use of benzodiazepines and opioids — including buprenorphine and methadone — carries an **FDA Black Box Warning** for profound sedation, respiratory depression, coma, and death. This is among the **most serious warnings** the FDA issues.
- My prescribing provider has thoroughly discussed this risk with me and has determined that the clinical benefit of benzodiazepine treatment outweighs the identified risk for the following documented indication:

- I **agree to** take benzodiazepines only as prescribed and not to obtain them from any other prescriber, pharmacy, or non-medical source without informing my provider.
- I **agree to store** benzodiazepines securely, away from children and others, and not to share or transfer them under any circumstances.
- I **agree to not** combine benzodiazepines with alcohol, cannabis, sleep aids, or any other CNS depressant not explicitly approved by my provider.
- I **understand** that this co-prescribing decision will be re-evaluated at every clinical visit and that benzodiazepines will be tapered and discontinued if the risks are determined to outweigh the benefits at any time.
- I **understand** that I have been offered and am encouraged to have naloxone (Narcan) accessible at all times given this combination.

Patient initials:_____

Prescribing Provider initials:_____

Date: _____

SECTION 6: CONFIDENTIALITY AND PRIVACY RIGHTS

6.1 – HIPAA Notice of Privacy Practices

Resolutions Wellness Group is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations (45 CFR Parts 160 and 164). **Your health information is private and protected.** We will not share your protected health information (PHI) without your written authorization, except as permitted or required by applicable law — including for emergency treatment, mandatory public health reporting, and legally required disclosures.

A copy of our **Notice of Privacy Practices (NPP)**, which describes your rights regarding your health information and how it may be used and disclosed, is available upon request at any time and has been provided to you today.

Notice of Privacy Practices provided and acknowledged: ____ Yes

Patient initials: _____

6.2 – 42 CFR Part 2 — Federal Protection of Substance Use Disorder Records

Your SUD Records Have Extra Federal Protection

Records related to your substance use disorder evaluation, diagnosis, or treatment — including MAT/MOUD — are protected by federal law under **42 CFR Part 2** (Confidentiality of Substance Use Disorder Patient Records).

These protections are stronger than standard HIPAA protections and apply specifically because you are seeking treatment at a federally assisted SUD program.

Under 42 CFR Part 2, your SUD treatment records **may not be shared** with any person or entity — including employers, family members, law enforcement, courts, or other healthcare providers — without your explicit written consent, except in the following very limited circumstances:

- A bona fide medical emergency in which disclosure is necessary to protect your health or life.
- A valid court order that specifically authorizes access to SUD records (a standard subpoena is not sufficient).
- Internal program audit or oversight by authorized regulatory agencies.
- Qualified service organization agreements (QSOAs) with entities providing services on behalf of this program.
- Reporting of suspected child abuse or neglect as required by state law, to the extent permitted under 42 CFR Part 2.

This means that if someone — including a family member, employer, or law enforcement officer — contacts this clinic asking whether you are a patient here, **we are prohibited by federal law** from confirming or denying your enrollment without your written authorization.

Patient acknowledges 42 CFR Part 2 education: ____ Yes Patient initials:_____

6.3 – Mandatory Reporting Obligations Under Texas Law

Although confidentiality is a cornerstone of our care, Texas law imposes specific mandatory reporting obligations on healthcare providers. **We are required by law to report the following, regardless of patient consent:**

- **Suspected** abuse, neglect, or exploitation of a child — Texas Family Code §261.101. Reports are made to the Texas Department of Family and Protective Services (DFPS).
- **Suspected** abuse, neglect, or exploitation of an elderly or disabled adult — Texas Human Resources Code §48.051. Reports are made to DFPS Adult Protective Services.
- **Certain** communicable diseases and health conditions to the Texas Department of State Health Services (DSHS) as required by Chapter 81 of the Texas Health and Safety Code.
- **Imminent** threat of serious harm to an identifiable third party — Texas Health and Safety Code §611.004 (duty to warn / Tarasoff obligation). If you communicate a specific and credible threat of physical harm against an identifiable person, we have a legal and ethical duty to take protective action, which may include notifying that person and/or law enforcement.

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We will make **every effort** to inform you if a mandatory report is being made and to discuss how it may affect your care, unless doing so would create a safety risk.

Patient acknowledges mandatory reporting education: ____ Yes

Patient initials: _____

6.4 – Telehealth Services

Resolutions Wellness Group may offer services via telehealth (synchronous audio-video or audio-only). If you receive services via telehealth, I **understand** and **agree** to the following:

- Telehealth visits are conducted over a HIPAA-compliant, encrypted video or audio platform. The clinic will communicate the specific platform in use.
- I am responsible for ensuring my own privacy during telehealth sessions — finding a private, secure location and using a private internet connection.
- Telehealth has certain limitations compared to in-person visits, including the inability to conduct a full physical examination, perform in-office testing, or administer injectable medications.
- The prescribing of controlled substances via telehealth is subject to DEA regulations and may require an in-person evaluation before prescribing can occur, depending on current federal rules.
- I consent to receive clinically appropriate services via telehealth when scheduled and mutually agreed upon with my provider.

Patient consents to receive services via telehealth when offered Patient declines telehealth — in-person only preference noted.

SECTION 7: PATIENT RIGHTS AND RESPONSIBILITIES

7.1 – Your Rights as a Patient

As a patient at Resolutions Wellness Group, **you have the following rights:**

1. To receive **respectful, non-discriminatory,** and culturally sensitive care regardless of race, ethnicity, national origin, gender identity, sexual orientation, religion, disability, age, or socioeconomic status.
2. To be **fully and clearly informed** about your diagnosis, treatment options, the risks and benefits of those options, and available alternatives — in language and terminology you understand. Interpretation services are available upon request.
3. To **actively participate** in your treatment planning and to have your values, preferences, and goals respected and incorporated into your care.
4. To **refuse or withdraw** consent for any component of treatment at any time, and to receive a clear explanation of the clinical consequences of that decision without fear of judgment or retaliation.
5. To **access and request** copies of your medical records in accordance with HIPAA within the timeframes required by law.
6. To file a **grievance** or **complaint** regarding your care or the conduct of any staff member without fear of retaliation or adverse impact on your treatment. Patient Advocate contact:
7. To file a **complaint with the Texas Medical Board** (tmb.state.tx.us | 1-800-201-9353) regarding medical provider conduct, or the Texas State Board of Pharmacy (pharmacy.texas.gov) regarding pharmacy or prescribing concerns.
8. To **receive information** about clinical outcomes, quality improvement processes, and patient satisfaction programs at this clinic.
9. To receive a **Good Faith Estimate of expected costs** for services before receiving care, as required by the No Surprises Act (effective January 1, 2022).
10. To **be treated at all times** with dignity, compassion, and respect, and to have your privacy and confidentiality protected as described in this document.

7.2 – Your Responsibilities as a Patient

In **partnership** with your care team, you **agree** to the following responsibilities:

11. **Provide** accurate, complete, and honest information about your health history, current substance use, all medications you are taking (prescribed and non-prescribed), and any current symptoms or concerns. Incomplete or inaccurate information can significantly affect the safety and effectiveness of your care.
12. **Attend all** scheduled appointments on time or provide advance notice of cancellation in accordance with the clinic's scheduling and no-show policy.

13. **Take all prescribed** medications only as prescribed, store them safely and securely, and never share, sell, or transfer them to another person.

14. **Promptly notify** the clinic of any changes in your health status, mental health symptoms, other medications prescribed by other providers, new medical diagnoses, insurance, or contact information.

15. **Participate actively** in your treatment, including counseling, behavioral health services, and recovery support as recommended and agreed upon in your individualized treatment plan.

16. **Treat all clinic staff, providers, and other patients** with courtesy and respect. Aggressive, threatening, or disruptive behavior will not be tolerated and may result in discharge from the practice.

17. **Arrive to all** appointments in a sober state, not under the acute influence of alcohol or illicit substances. Appointments may be rescheduled if this responsibility is not met.

18. **Fulfill your financial obligations** to the clinic in accordance with your signed financial agreement, including co-pays, deductibles, and any balances not covered by insurance.

SECTION 8: CRISIS AND EMERGENCY RESOURCES

If you or someone else is in immediate danger, call 911 or go to your nearest emergency room now.

This clinic does not provide 24-hour emergency or crisis response services. Please save these numbers in your phone.

Resource	Contact	Availability
988 Suicide and Crisis Lifeline	Call or Text **988**	24 / 7
Crisis Text Line	Text HOME to **741741**	24 / 7
Poison Control Center	1-800-222-1222	24 / 7
Texas Opioid Help Line	1-800-584-1330	24 / 7
NAMI Texas Helpline	1-800-633-3760	M–F, 9AM–5PM CT
National Domestic Violence Hotline	1-800-799-7233	24 / 7
Veterans Crisis Line	Call/Text **988**, then press **1**	24 / 7
Trevor Project (LGBTQ+ Youth)	1-866-488-7386	24 / 7
Clinic After-Hours Contact		
Nearest Emergency Room		

SECTION 9: FINANCIAL CONSENT

I understand and agree to the following financial responsibilities associated with my care at Resolutions Wellness Group:

- I am responsible for any co-pays, deductibles, co-insurance, or outstanding balances not covered by my insurance plan, payable at the time of service unless other arrangements have been made in advance.
- I authorize Resolutions Wellness Group to bill my insurance carrier on my behalf and to release necessary health information required for claims processing.
- I understand that some services may not be covered by my insurance plan. The clinic will make reasonable efforts to inform me in advance of any services that may not be covered.
- I have received or been offered a Good Faith Estimate of the expected cost of services before receiving care, as required by the federal No Surprises Act.
- I understand the clinic's financial assistance and/or sliding-scale fee policy (if applicable):
- I understand that repeated non-payment of balances may affect my ability to continue receiving services at this clinic, and that I will be given advance notice before any such action is taken.

Financial Agreement acknowledged: ____ Yes Patient initials:_____ Date: _____

SECTION 10: ACKNOWLEDGMENT AND SIGNATURES

I _____confirm and attest to the following:

- I have read this entire Consent for Treatment document, or it has been read to me in a language I understand. A copy has been offered to me for my records.
- I have had a full and adequate opportunity to ask questions, and all my questions have been answered to my satisfaction by my provider or clinic staff.
- I understand the nature of the treatment services offered at Resolutions Wellness Group, including the risks, benefits, and available alternatives.
- I understand my rights and responsibilities as a patient of this clinic as described in Section 7 of this document.
- I voluntarily consent to the evaluation, treatment, and services provided by Resolutions Wellness Group, without coercion or undue influence.
- I understand that this consent remains in effect for the duration of my active treatment at this clinic but may be withdrawn in writing at any time, and that such withdrawal will not adversely affect other aspects of my care.

- I understand that certain procedures, specific medications, or special circumstances may require additional specific informed consent forms beyond this general consent document.

Summary of Consents — Please initial each applicable item:

Init.	Consent Item
	Patient consents to addiction treatment services (Section 2)
	Patient consents to psychiatric evaluation and medication management (Section 3)
	Patient consents to telehealth services when clinically appropriate (Section 6.4)
	Patient acknowledges 42 CFR Part 2 federal SUD record protections (Section 6.2)
	Patient acknowledges Texas mandatory reporting obligations (Section 6.3)
	Patient acknowledges financial responsibility for services (Section 9)
	Patient acknowledges receipt of Notice of Privacy Practices (Section 6.1)

Patient Signature:

Patient Signature: _____ Date: _____

Printed Legal Name: _____

Parent or Legal Guardian Signature (if patient is a minor or legally incapacitated):

Parent/Guardian Signature: _____ Date: _____

Printed Name : _____ Relationship to Patient: _____

Witness / Clinic Staff:

Witness / Staff Signature : _____ Date: _____

Printed Name : _____ Role /Title: _____

Treating Clinician / Provider (if present at time of consent):

Clinician / Provider Signature: _____ Date: _____

Printed Name : _____ Credential / License Number : _____

SECTION 11: CONSENT REVISION LOG

This log documents any updates, amendments, or re-consenting events that occur during the patient's treatment at Resolutions Wellness Group. All revisions require patient initials and provider documentation.

Date	Provider Name / Credential	Summary of Change or Reason for Re-Consent	Patient Initials

Document Control Information

Form Title: Consent for Treatment | Form Version: 1.0 | Effective Date: _____ | Review Date: _____

Reviewed and Approved by: _____ | Title: _____

This document supersedes all prior versions of the Resolutions Wellness Group Consent for Treatment form.

This document was prepared for use by Resolutions Wellness Group, an outpatient addiction medicine and psychiatric services clinic operating in Texas. It is intended as a clinical and administrative tool and does not constitute legal advice. Resolutions Wellness Group recommends periodic legal and regulatory review of all consent documents to ensure continued compliance with applicable federal and Texas state law, including but not limited to HIPAA (45 CFR Parts 160 & 164), 42 CFR Part 2, the Texas Health and Safety Code, and relevant DEA regulations governing controlled substance prescribing. This document should be reviewed and updated whenever applicable laws or clinical practices change significantly.