Triangle NeuroPsychiatry PLLC

Adult Consent to Treat

I _____ acknowledge that I am a patient at Triangle NeuroPsychiatry, PLLC. By signing this form I consent that I will be treated by the providers at this practice.

1. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical recommendations and treatments with the provider
   - that being treated by any provider at **Triangle NeuroPsychiatry, PLLC** is my choice and I have the right to change medical providers at any time.

2. I understand that treatment and services may include:
   - Lab tests, including random drug screens
   - Screening tests (tests that can find an illness early, before a person shows signs of having the disease),
   - Diagnostic tests (tests that show if a person has a certain illness or health problem), and
   - Routine exams

3. I understand that no promises have been made to me about the results of any treatment or services.

4. I understand that I grant permission that allows providers and staff of Triangle Neuropsychiatry to seek emergency medical care for me from a hospital or other physician.

5. I have been informed of the right to treatment, including access to medical care and habilitation, regardless of age or degree of MD/IDD/SA disability.

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

_____ _____

Witness Signature Date

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