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**Medical & Mental Holistic Healthcare**  
138 Park Ave, Ste 206  
Winder, GA 30680  
Office: (770) 240-4849 | Fax: (678) 737-1743

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**GENERAL PATIENT CONSENT FORM**

**Patient Information**

Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Sex at Birth / Gender Identity: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number / Email: \_\_\_\_\_

Emergency Contact (Name, Relationship, Phone): \_\_\_\_\_

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Preferred Language: \_\_\_\_\_

Insurance (if not already captured): \_\_\_\_\_

Name of Procedure/Treatment: \_\_\_\_\_

Date: \_\_\_\_\_

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**Consent Statement**

I consent to psychiatric and/or medical evaluation and treatment, including medication management and supportive psychotherapy, provided by **Nadine Williams, PMHNP-C, AGNP-C**. I understand that treatment may include discussion of sensitive topics and the use of psychotropic medications or other treatments that carry potential risks and benefits.

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**I acknowledge that:**

1. The procedure/treatment has been explained to me in terms I understand, including its nature and purpose.
2. I have been informed of the potential risks, benefits, and available alternatives.
3. I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.
4. I understand that I may refuse or withdraw consent at any time without affecting my right to future care.

5. I authorize the provider and clinical team to perform additional procedures deemed necessary based on professional judgment.
  6. I understand that no guarantees have been made regarding outcomes of treatment.
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**Visit Type (Check all that apply)**

- Initial Assessment
  - Follow-Up Visit
  - Wellness Visit
  - Sick Visit / Urgent Care
  - Telehealth Visit
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**Telehealth Consent (If Applicable)**

- I consent to receive healthcare services via telehealth.
  - I understand the limitations and potential risks of telehealth.
  - I agree to be physically located in my reported state during telehealth visits.
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**HIPAA & Financial Policy Acknowledgment**

- I acknowledge receipt of the Notice of Privacy Practices.
  - I understand and agree to the financial policy, including:
    - Copays and deductibles
    - Missed appointment policy
    - Self-pay responsibility
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**Signatures**

Patient/Representative Name (Print): \_\_\_\_\_

Relationship to Patient (if applicable): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Name (Print): \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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