MINDSPACE INTEGRATED CARE LLC

Consent for Psychiatric Treatment

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Consent

I voluntarily consent to psychiatric evaluation and treatment by Mindspace Integrated Care LLC and its providers.

I understand treatment may include diagnostic interviews, medication management, and referrals as clinically appropriate.

I understand no specific outcome has been guaranteed and that I may withdraw consent at any time.

Telehealth (if applicable)

I understand telepsychiatry visits are conducted via secure video and are limited to residents physically located in Virginia at the time of the visit.

I understand technical failures may interrupt visits and that alternate contact by phone may be used.

Financial Responsibility

I understand I am responsible for any co-pays, deductibles, or fees not covered by insurance.

I understand a 24-hour cancellation notice is required to avoid a late-cancellation fee.

Signature: _____ Date: _____