ORLANDO PSYCHIATRIC ASSOCIATES

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INFORMED CONSENT FOR TREATMENT

I understand the concepts and conditions of informed consent, privacy and confidentiality.

I understand that I have the opportunity to discuss these concepts and conditions and ask for clarification of parts which I am concerned about or not fully understand.

I understand that I will be informed of the goals, expectations, procedures, benefits and possible risks involved in the treatment.

I understand that my initial visit will be an initial evaluation only, which will not guarantee the continuation of care at OPA, or same medications prescribed by other providers.

I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-explanation, and responsible action. It has the overall purpose of promoting understanding the change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/ treatment. I have the right to refuse or withdraw from any counseling, evaluation, or medication management unless otherwise specified by law.

My clinician informed me of the nature of the treatment and has explained to me the risks and benefits of the medication. I understand that although OPA clinician has explained to me the most common side effects (including antidepressants FDA black box warning for children only) of this treatment I should promptly inform clinicians or staff if there are any unexpected changes in my condition.

I also give permission to OPA to communicate by phone, email, or voicemail in regards to my RX care.

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Patient /Guardian Signature Date

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Witness signature Date