Consent Form for the Following:

Mental Health Evaluation, Mental Health Treatment AND/OR Medication Management

1. Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health (e.g., psychological or psychiatric) evaluation and treatment, as necessary, by staff from Cedar Valley
Psychiatry, LLC. I understand that following the evaluation, complete, accurate and educational information will be provided concerning each of the following areas:

a. My Diagnosis.
b. My Prognosis.
c. The proposed treatment, including the benefits of the proposed treatment.
d. The manner in which treatment will be administered.
e. Expected side effects from the treatment and/or the risks of side effects from medication(s) (when applicable).
f. Probable consequences of not receiving treatment.
g. Alternative treatment modes and services.

The evaluation and treatment will be conducted by a psychiatrist, social worker, or therapist. Evaluation and treatment will be conducted in accordance with applicable state and federal laws. Communication and coordination of care will be done regularly between the psychiatrist and other treating providers/team members from Cedar Valley Psychiatry.

2. Medication(s) Consent: I am the patient and/or legal guardian and I consent to the administration of this psychiatric medication if needed. I have been educated regarding the possible side effects of medication(s) (when applicable), possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication(s) if the person taking this medication(s) becomes pregnant. I have also been informed of the reason or purpose for which this medication(s) was prescribed.

a. It is recommended that women who are or may become pregnant, or are breast-feeding discuss this with their doctor **before** taking **any** medication.
b. It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **immediately** to a health care provider.

3. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

4. Charges: Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. Fees are available to me upon request.

5. Right to Withdraw Consent: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

By signing this form, I indicate that I have read and understand the above, have had an opportunity to ask questions about this information, and consent to the evaluation and treatment.

I also attest that **I** have the right to consent for evaluation and treatment. **I** understand that **I** have the right to ask Cedar Valley Psychiatry, LLC questions about the above information at any time.

_____ _____

Signature of patient ages 14 years or older **Date**

_____ _____

Signature of Legal Guardian **Date**

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