Harmony United Psychiatric Care

Consent for Treatment/Medication

This is a required form that must be completed for service

I, _____am the Client/Patient or Parent/Legal Representative of Client/Patient. I understand that the healthcare Provider(s) at Harmony United Psychiatric Care will discuss my, my child's or my Client's condition and treatment options with me. If I, my Child or my Client require psychiatric treatment and/or psychotropic medications, the Provider(s) will recommend that I, my Child or my Client receive psychotherapy/counseling and/or conjoint psychotherapy along with medication management for the treatment of my, my Child's or my Client's illness. I understand that I, my Child or my Client may not be compelled to take prescribed medications and that I, my child or my Client may decide to stop taking medications at any time. I also understand that I, my child or my Client has the right to terminate treatment with Provider(s) at Harmony United Psychiatric Care at any time I choose to do so by stating my decision in writing.

I understand that it is my responsibility to inform my, my Child's or my Client's healthcare provider(s) of my, my Child's or my Client's medical and psychiatric background. I understand that refusal to abide by prescribed treatment (e.g.: not taking or overtaking prescribed medications, missing, or rescheduling appointments repeatedly, etc.) is a basis for termination of care due to noncompliance. I also understand that although my, my Child's or my Client's healthcare provider(s) at Harmony United Psychiatric Care believe this treatment will be of benefit to me, my Child or my Client, there is no guarantee as to the results that I, my child or my Client may expect.

With this understanding, I authorize my, my Child's or my Client's healthcare provider(s) at Harmony United Psychiatric Care to render the necessary psychiatric services as deemed advisable, including but not limited to psychiatric medication management, psychotherapy /counseling, neuropsychological testing, etc. I, my Child or my Client also consents to take psychotropic medications prescribed to me, my Child or my Client if necessary, for the treatment of my, my Child's or my Client's mental health condition. The Provider(s) will discuss the risks, benefits and alternatives with me when the medication is prescribed to me, my Child or my Client. I understand and consent for Treatment/Medication.

Consent for Utilizing Surescripts

I also give my consent to retrieve and use my, my Child's or my Client's medication history from Surescripts.

_____ _____

Signature of Client/ Patient or Parent/ Legal Representative Date

_____

Print Name

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