CONSENT FOR MEDICAL TREATMENT

I, the undersigned patient, do hereby voluntarily consent to such treatment involving routine diagnostic procedures and medical treatments as are considered necessary by Christell Lara, M.D., P.A. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examination rendered.

I authorize Dr. Christell Lara to carry out psychological testing, evaluation, treatment and/or other diagnostic procedures which now, or during the course of my treatment, are reasonable and necessary. I understand that the purpose and goals of these procedures will be fully explained to me at any time upon my request and that they are subject to my agreement and voluntary participation.

I agree to participate fully in my treatment and understand that a lack of commitment on my part to the treatment process may lead to disappointing results and may be grounds for termination of treatment. I understand that experiencing uncomfortable feelings such as anger, frustration, depression, and stress are possible side effects of the treatment process. I understand that this can be a normal response to working through life experiences and that these reactions will be worked on as a therapeutic issue if I bring them to the attention of my doctor.

Patient/Guardian Signature:_____
Date:_____

MEDICATION CONSENT

My physician has prescribed the following type(s) of medication for treatment:

- Antidepressant medications
- Antipsychotic medications (Neuroleptics)
- Anti-cyclic medications (Lithium/Anticonvulsants)
- Anti-anxiety medications
- Stimulants
- Other

My physician has discussed with me the nature of my mental health and the reasons why the above medication(s) have been prescribed, including the likelihood of my mental health improving with medication or not improving without medication.

It has been explained to me that effective medication may cause side effects in some people, but that most people experience few or no side effects. These side effects have been explained to me and I have been asked to notify staff as soon as possible if I develop any of these side effects.

If neuroleptics have been prescribed, my physician has told me that this medication may produce persistent involuntary movements of the face and mouth and at time similar movements of the hands and feet. In certain cases, these symptoms may be irreversible and may appear after the medication has stopped. This side effect is usually associated with taking medication for more than three months and can be minimized by lowering the dosage of the medication and minimizing the use of other medications. It has been explained to me that periodic examinations will be conducted to see if such involuntary movements have developed.

I have been given the opportunity to ask questions regarding my mental health and the medication treatment.

Based on this explanation, I hereby consent to treatment with the above prescribed medication. I understand that I may withdraw this consent at any time.

Patient/Guardian Signature: _____ Date: _____