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Mohammad M. Qasaymeh, MD
Michelle M. Rainka, PharmD
Luisa Rojas, MD
Nicolas Saikali, MD
Lixin Zhang, MD, PhD
Joseph V. Fritz, PhD, CEO

DNI Psychiatric Clinic - Consent for Evaluation and/or Treatment

Consent to Evaluate/Treat: I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from DENT Neurologic Institute. I understand that following the evaluation and/or treatment, information will be provided concerning each of the following areas:

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

The evaluation or treatment will be conducted by a psychiatrist, a psychologist, a physician's assistant, a nurse practitioner, a licensed social worker or an individual supervised by any of the professionals listed.

1. **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. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning. So that the appropriate recommendations and treatments may be offered. Use of this evaluation includes diagnosis, evaluation of recovery or treatment estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment includes improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
2. **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.
3. **Release of Information Consent:** Specific description of information to be used or disclosed under this consent for the purpose of continuity of care to referring/ primary care physician: diagnosis, presence in treatment, recent medical exam results, lab test results, treatment recommendations, prescribed medications, diagnosis, follow up recommendation, treatment plan and progress.
4. **Right to Withdrawal 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. The withdrawing of my consent for this treatment will not prejudice my continued treatment relationship.
5. **Expiration of Consent:** This consent will remain valid as long as I am an active patient in the Psychiatry Clinic at the DENT Neurologic Institute.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent to treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

______________________________ ____________

Print Name of Patient **DOB**

______________________________ ____________

Signature of Patient/Parent/Legal Guardian **Date**

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