# CONSENT FOR TREATMENT

By signing this document, I agree to participate with Dr. Mary Wyant and/or her designee(s) in my treatment. I understand that this treatment may involve medication, with laboratory monitoring, individual and/or group psychotherapy, or other treatment modalities.

I agree to discuss any medications or substances that I may be taking, including over the counter medications, recreational drugs, alcohol, or any herbal medications. I also agree to inform the doctor of my complete health status and any changes in my health status during the course of treatment. I understand a physical exam is recommended every year.

I understand all aspects of my treatment are held in strict confidentiality, and written consent is required for any aspect of my treatment to be communicated to another party. However, in cases of the possibility of significant dangerousness to myself or others, the rule of confidentiality may be superseded. I understand the law requires all cases of suspected child abuse/neglect be reported to the authorities.

I understand and agree to inform Dr. Wyant and go to the nearest emergency room immediately should I experience overwhelming thoughts or impulses that involve harm to myself or others, that I do not believe I can control. I have been given phone numbers, and instructions about calling in case of emergency, including the use of 911.

I understand that, should hospitalization be required, my inpatient care will be referred to another psychiatrist. I understand that I will be given assistance in finding another psychiatrist, should a referral be necessary.

I also understand that, unless prior arrangements have been made, I am responsible for filing my own insurance. I understand that because of the importance of the doctor- patient relationship, regularly scheduled appointments are required in order for Dr. Wyant to prescribe medication, and that five business days should be allowed for medication refill requests.

I am entering treatment with my full and voluntary consent, and I accept responsibility for discussing fully any aspect of treatment that I may not understand, or about which I may have reservations.

Signature _____

Date _____

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