CONSENT FOR EVALUATION AND TREATMENT

Name of Patient: _____ **DATE:** _____

I acknowledge that I am voluntarily seeking medical evaluation by Dr. Milena Newhook, DO, PA. I understand that, as part of that process, I may be recommended to receive diagnostic testing, psychological testing, psychotherapy and/or medication management. I understand that I have the ability to decline the aforementioned services at any time, but his may affect my treatment process and outcome.

The following types of medications are commonly prescribed to treat psychiatric conditions:

- **Antidepressants**
- **Antipsychotics**
- **Mood stabilizers**
- **Anxiolytics**
- **Stimulants**

Possible adverse reactions and alternatives to these medications have been discussed with my physician and I had the opportunity to ask questions regarding my evaluation and treatment.

I also understand that refusal to comply with Dr. Newhook's recommendations could result in grounds for termination of the patient-physician relationship. I also understand I have the right to terminate the relationship at anytime.

Signature: _____ **DATE:** _____

Witness: _____ **DATE:** _____