Howard Medical Corp

101 West Avenida Vista Hermosa, Suite 122
San Clemente, CA 92672
Phone: (949) 212-2699 Fax: (888) 999-8503
www.HowardMedicalCorp.com

Consent To Participate in Psychiatric Consultation

Purpose: The purpose of this form is to obtain your consent for a psychiatric consultation with a medical provider.

The Informed Consent Statement

Thank you for choosing Howard Medical Corp. We want you to know what to expect as you participate in treatment at our office. We offer both medication management and counseling for the treatment of psychiatric and psychological disorders.

If you see a provider that can prescribe medications, he/she may see fit to prescribe one to you for the treatment of your symptoms. This is something that you and your provider will discuss and decide together. For treatment to be effective, medications must be taken as prescribed. With any medication, there are always risks of side effects that you and your provider will discuss. Results cannot be guaranteed for everyone, however with patients in continued care, excellent results are often achieved.

If you choose counseling or if one of the providers refers you to counseling your therapy will involve discussion of personal issues. At times these may feel somewhat uncomfortable to discuss. Counseling relationships take time to develop just like any other relationship. Often it is important to be seen several times before you make a decision about whether or not it is a good fit. Therapy or counseling is not helpful to everyone but frequently when combined with prescribed medications can be extremely beneficial.

All of your treatment at Howard Medical Corp is kept confidential. No information will be released without your written consent unless your clinician feels you are a danger to yourself or others. Releasing information to any agency or individual will require a signed release of information. HIPAA information is provided during your first visit and is also available by download from our website if you have further questions about our privacy policy. We want you to feel comfortable and satisfied with your care. If you have questions or concerns do not hesitate to ask any of our staff.

We apologize in advance but you will also need to sign a similar consent if you choose to participate in Telehealth services

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the consultation(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient or Patient's Representative	Date of Signing
Relationship of Representative to Patient	Name of Interpreter / ID #
Signature of Witness (required if patient is unable to sign)	Date of Signing