CONSENT FOR TREATMENT

STANLEY A. COHEN, D.O.
Professional Association
Child, Adolescent & Adult Psychiatrist

Patient Name: _____ DOB: _____

My signature below authorizes Dr. Cohen and/or his clinical associates to administer treatment that may be deemed appropriate for my condition. I understand that psychiatry/mental health treatment is not easily described in general statements and that there are many different methods that can be used to deal with the problems and calls for a very active effort on my part.

I have been informed of the nature and purpose of the treatment options. I understand that, although the doctor/clinical associates have explained to me the most common side effects of this treatment, there may be other side effects or other changes in my condition that I should report promptly to the doctor/office staff.

I understand that I may not be compelled to continue treatment and I may request at any time that it be discontinued. I also understand that there is no guarantee as to the results that may be expected. Due to the nature of psychiatric/mental health/alcohol and drug disorders, there can be no guarantee of treatment effectiveness nor that the outcome will be as expected by me and/or my family.

I understand that Dr. Cohen and/or his clinical associates encourage the patient to discuss treatment with family members and that he/she is available to explain the treatment program and the risks, versus the benefits of the program. I understand that a treatment program is based on the information given by me or family. A second opinion by another physician or therapist is a part of my options.

I understand that psychiatric treatment requires continuous monitoring. I will not stop my medication unless I discuss this change with Dr. Cohen and/or his clinical associates because of the possibility of discontinuation side effects. In case of an adverse effect due to the medicine, I will contact Dr. Cohen's office immediately. I will follow up with Dr. Cohen and/or his clinical associates on a regular basis as is in accordance to my discussed treatment plan. If I cancel a scheduled appointment, I will promptly call to reschedule. If I desire to terminate treatment, I will discuss my desire with my provider, and if I do not return within **5 months**, my case will be closed and services will be terminated. I will seek help from another provider. If I desire to return to Dr. Cohen's practice, I understand that I will be treated as a new patient or may not be accepted back at the discretion of Dr. Cohen and/or his clinical associates.

This consent can be revoked orally or in writing prior to or during treatment. I will discuss any questions pertaining to this consent with my provider.

Patient Signature: _____ Date: _____
Office Signature: _____ Date: _____