

INFORMED CONSENT TO TREAT WITH MEDICATION

I, _____, do hereby authorize my prescribing physician or nurse practitioner and any other providers working for (or prescribing for) Riddle Psychiatry, LLC to prescribe the following medications:

I understand that the reason this/these medications are being prescribed is to treat my illness. Furthermore, by signing this Consent Form I am confirming that my provider has informed me of the nature of my treatment, the type of medication that I am taking and any subsequent risks or side effects associated with these medications. I also confirm that I understand the risks and side effects associated with these medications:

Please check and initial one choice below:

I am allergic to _____ Initial: _____

I have no known allergies to medications Initial: _____

Female Patients:

Yes, I am pregnant. My provider informed me of potential risk to me and my developing, new-born, or breast-fed baby that may occur due to taking this medication. My provider also explained how taking these medications while pregnant/ breast-feeding may be beneficial to me. We agree together that the potential benefits outweigh the potential risk.

No, I am not currently pregnant. I understand that taking these medications may carry risk of harm to a developing, new-born or breastfed baby. I agree to discuss any plans for pregnancy with my provider as soon as possible.

I understand that I may not be compelled to take these medications and that I may discontinue these medications at any time. However, I further understand that if I stop taking these medications abruptly, that I may experience serious side effects and therefore, I should not discontinue, change or adjust any medications without the awareness of my provider.

OFF LABEL MEDICATIONS: The use of drug to treat a condition or target symptoms, even though the drug is not specifically approved to do so by the US FDA.

BLACK BOX WARNING: The strictest warning put in the labeling of prescriptions drugs or drug products by the US FDA when there is reasonable evidence of an association of serious hazards with the drug

My signature below indicates:

- I understand the contents of this release as well as my rights with respect to agreeing to or refusing any medications suggested to treat my illness
- This consent form was discussed with me in detail and that all of my questions were answered to my satisfaction
- The nature or rationale of treatment with these medications, explanations of possible side effects and whether these medications or being prescribed for "OFF LABEL" use was also discussed and I have no further questions. Signing indicates that I believe the benefits outweigh the risk.

Patient Signature: _____

Date: _____

Prescriber Signature: _____

Date: _____