IglePsych, Inc.

14 Racetrack Rd. NW, Fort Walton Beach, FL 32547
Phone: (850) 374-3990
Fax: (850) 374 – 8133

CONSENT FOR TREATMENT

My signature below authorizes my mental health provider to treat me. I understand this could include medications, labs, or other diagnostic tests. I understand that my provider is available to explain the treatment. I intend that this consent form is to cover the entire course of treatment for my present condition and any future conditions for which I am seeking treatment here.

I am aware that I have the right to refuse treatment and may discontinue treatment at any time. I am responsible for telling my doctor if I discontinue medication(s), are taking other new medications, or become pregnant or develop other medical conditions or side effects.

By signing below, I certify that I have read and understand the terms stated in this document and I consent to my treatment at IglePsych, Inc.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____