Consent For Treatment

Randy Brazie MD PLLC
Psychiatrist, SEP
Phone: 602-387-5185
Fax: 602-584-6136

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Randy Brazie MD PLLC. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

Name _____ Date of Birth _____
Date of service _____
Proposed treatment/procedure _____
I acknowledge that _____ has informed me of the following:

- My basic rights and responsibilities as a client
- The nature and details of the procedure/treatment
- The purpose of the procedure/treatment
- The potential risks and side effects of the procedure/treatment
- The potential benefits of the procedure/treatment
- That the procedure/treatment is completely elective
- Whether any limitations on the procedure/treatment could be implemented
- That the procedure/treatment is or is not one that is scientifically-tested or otherwise approved by a scientific organization

_____ I acknowledge that I have had the opportunity to ask all questions I have regarding this procedure/treatment. All questions have been answered to my satisfaction.

_____ I acknowledge that no guarantee, either expressed or implied, have been made to me regarding the outcome of this treatment/ procedure.

_____ I hereby authorize the above-named provider and designated associates and assistants to perform the procedure/treatment named above.

_____ I freely consent to the proposed treatment/procedure.

By signing this informed consent form:

_____I hereby grant authority to the provider to perform the procedure/treatment.

_____I agree to adhere to all safety precautions and pre/post instructions for the procedure/treatment, if any.

_____I understand that medicine is not an exact science and acknowledge that no guarantee has been given or implied by anyone as to the results that may be obtained by this treatment.

_____I hereby give my voluntary consent to this procedure/treatment and release the Randy Brazie MD PLLC, it's medical staff, and specific technicians from liability associated with the procedure/treatment.

_____I certify that I am a competent adult of at least 18 years of age and am not under the influence of alcohol or drugs.

_____I agree that if I should have any questions or concerns regarding my procedure/treatment or results I will notify Randy Brazie MD PLLC at the phone number listed above and/or the provider immediately so that timely follow-up and intervention can be provided.

Patient Signature Patient Name Date

Signature of Legal Guardian Name of Legal Guardian
Date(If patient is a minor)