Consent for Psychiatric Treatment and Medication Management

I hereby authorize **[Dr. Natoya QueenBourrows AAPRN, DNP,MSN, FNP-NP-C with QuBu Health and Management]** to provide Psychiatric treatment and psychotropic medication management as explained to me. I understand that while this medication management may be beneficial, as with any treatment, there are inherent risks. During medication adherence, I will report any concerns, side effect, or adverse reaction if experience and seek immediate medical attention.

Will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of counseling can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. I acknowledge, however, that no warranty or guarantee can be made as to the results of one medication, and make require dual treatment.

I was offered printed materials in my preferred language on my current medications, dosages and side effects. I understand that the decision to take any medication is solely up to me, and I understand the potential risks and benefits of the medication(s) listed on this form as they've been explained to me. I may withdraw my consent for any medication at any time by signing a Medication Consent Withdraw form for that medication(s). I know I should always first discuss with my psychiatric prescriber any decision to increase, decrease, or to abruptly stop taking any medications and any decision by myself or any other provider to add or remove a medication that my psychiatric provider didn't know about when I consented for the medication(s) listed on this form. It is my responsibility to keep my psychiatric provider updated on any medications I take from any source. I understand that my psychiatric provider believes the medication(s) listed on this form and used by me only as prescribed will help me, but I know there is no guarantee as to the results.

CONFIDENTIALITY: I understand that discussions between myself and my Provider as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the provider has a duty to disclose, or where, in the provider judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the provider, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my provider. By signing this Information and Consent Form, I am giving consent to the undersigned provider to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless the undersigned provider from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my provider believes that I am in physical or emotional danger or I

am a danger to another human being, I understand that my provider is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: psychiatric treatment and medication management as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I am voluntarily agreeing to receiving mental health assessment, medication management, psychiatric medication, treatment and services for me, and I understand that I may stop such treatment or services at any time.

Client Signature	Date
Therapist Signature	Date