

Cogent Psychiatric Services

Certification of the Informed Consent for Treatment

I, the patient certified on this document, agree and consent to participate in the behavioral health care services offered and provided by the psychiatrist. I have been informed of the reason and purpose for which the medication has been prescribed. Also, I have been educated about the following medications that have been prescribed to me, including the possible side effects and drug-to-drug interactions that may occur. I understand that I have to inform the psychiatrist if I am pregnant (applicable to female patients).

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

Medication: _____ Date: _____

The Patient completely and precisely understands the risks involved with the utilization of medications and provides the authorization and consent to willfully incur any and all risks associated with the adverse effects of the prescribed medications. The Patient acknowledges the understanding and the assumption of the risks generated due to the usage of medications.

Patient's Name: _____ Date: _____

Patient's Signature: _____

Psychiatrist's Name: _____ Date: _____

Psychiatrist's Signature: _____