3C CLINICAL COUNSELING
&Consulting Services, PLLC
ASSESSMENT AND TREATMENT CENTER
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Medication Management Informed Consent

By my signature below, I consent to participate in medication management of prescribed medication by a Medical Doctor or Physician Assistant or Nurse Practitioner under the supervision of a Medical Doctor (referred to as “agents”) employed by Clinical Counseling and Consulting Services, PLLC (CCCS), where permitted by law. I also release CCCS and agents from all liability, including acts of omission or commission, resulting or arising from my prescription of the medication.

- I have voluntarily chosen to receive the medication.
- I am of legal age and authorized to execute this consent form.
- I will immediately alert CCCS and the prescribing agent of any medical conditions which may adversely affect my personal health or effectiveness of the medication.
- I have received education about potential side effects of the medication, when they may occur, and when and where I should seek treatment.
- I understand that if I experience any side effects, I am responsible for following up with my prescribing agent.
- I have had the opportunity to ask questions about the medication, and all my questions have been answered. I understand the benefits and risks of the medication.
- I understand that my receipt of this medication is subject to reporting, by my pharmacy or CCCS and CCCS agents, to my primary care physician, the prescribing agent, and/or the medication manufacturer, if required, and I authorize these disclosures.
- I understand that a copy of my medical records will be stored in a confidential manner.

Informed Consent: In order to make an informed decision, you must be provided with information (verbal and/or written) including the following:

- The nature of your psychiatric condition (diagnosis).
- The reasons for taking such medication(s), include the likelihood of improving or not improving without such medication(s).
- The name, dosage, frequency, route of administration and duration of prescribed medication(s).
- The possible side effects of the medication(s) known to commonly occur and may possibly cause birth defects. Additional side effects may occur with continued administration of an Antipsychotic medication(s) if taken for more than three (3) months. Side effects may include persistent involuntary movements of the face, mouth, limbs, and trunk, called tardive dyskinesia. These symptoms may be irreversible and may continue to appear even after the medication(s) has been discontinued.
- Duration and continuation of medication(s) will be discussed with you and your treating Psychiatrist/Nurse Practitioner during each visit.

Confidentiality: We maintain strict and firm policy of confidentiality about your personal information and matters related to your treatment. No information about you or your family will be given to another individual or agency without your written authorization. The only exception includes life-threatening emergencies, a court subpoena of records, or instances involving our ethical and legal duty to report abuse of children, elder adults, or disabled individuals. I understand in all cases any personal identifying information will not be used without my written permission.

Signatures

My signature below indicates that I have read and understand the items listed above. I am acknowledging that I agree with the information presented within, and by initialing the statements above, agree to each item as indicated.

_____ _____

Patient/Legally Responsible Person **Date**

OFFICE USE ONLY
*Patient Demographic
label HERE*