Penny Chow, M.D., P.A.
52 Sugar Creek Center Blvd. Ste 225
Sugar Land, TX 77478
Tel: (281) 494-6222 Fax: (281) 494-6220

Consent for Evaluation and Treatment

Name of Patient: _____ Date: _____

Name of Parent or Guardian: _____
(Patient is a minor or under guardianship)

I voluntarily consent to and authorized Dr. Penny Chow to perform evaluation and treatment for the purposes of my medical care. I understand this may include diagnostic testing, psychological testing, psychotherapy, medication management, and other appropriate alternative treatments.

I understand the non-compliance to medication could result in withdrawal symptoms that may require treatment in the emergency room.

I understand psychiatric medications could be prescribed off label for treatment of my condition as standard of practice in the community. I will be informed of such practices and given opportunity to ask questions and participate in my care.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian Date

_____ _____
Signature of Witness Date