**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.

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Signature of Patient Date

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Signature of Guardian Date

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Signature of Witness Date