# Adamfopa Outpatient Psychiatry, PLLC

## Consent for Psychiatric Treatment

### Purpose of Treatment

I understand that I am seeking outpatient psychiatric evaluation and/or treatment, which may include diagnostic assessment, medication management, and supportive therapeutic interventions.

### Nature of Psychiatric Care

I understand that psychiatric treatment may involve discussion of personal, emotional, or psychological issues and that outcomes cannot be guaranteed.

### Medications

If medications are prescribed, I understand:
- The purpose of the medication
- Expected benefits
- Common and serious side effects
- Alternatives, including no medication

I understand that it is my responsibility to report side effects and follow medication instructions as prescribed.

### Risks and Benefits

I understand that all treatments carry potential risks and benefits, and that no specific outcome is promised or guaranteed.

### Alternatives

I understand that alternatives to psychiatric treatment may include psychotherapy alone, referral to another provider, or choosing not to pursue treatment.

### Voluntary Participation

I understand that participation in treatment is voluntary and that I may withdraw consent or discontinue treatment at any time, except in circumstances involving immediate safety concerns.

### Telepsychiatry (if applicable)

I understand that services may be provided via telehealth and that:
- Telepsychiatry has potential risks, including technical failures or limitations
- Reasonable safeguards are in place to protect privacy
- I may request in-person services when available

### Emergency and Crisis Situations

I understand that Adamfopa Outpatient Psychiatry, PLLC does not provide emergency or crisis services. In case of an emergency, I agree to call 911, go to the nearest emergency room, or contact 988 (Suicide & Crisis Lifeline).

### Financial Responsibility

I understand that I am financially responsible for charges not covered by insurance, including missed appointments or late cancellations, according to clinic policy.

### Acknowledgment and Consent

I have had the opportunity to ask questions and understand the information provided above. I voluntarily consent to psychiatric evaluation and treatment at Adamfopa Outpatient Psychiatry, PLLC.

### Patient Information & Signature

Patient Name

Date of Birth

Patient Signature

Date