Luminox Healthcare Services, LLC
Informed Consent for Administration of Psychotropics

Effective Date: [Insert Date]

Purpose of This Consent
This document explains the potential benefits, risks, and alternatives to psychotropic medication. Psychotropics are prescribed to help manage mental health conditions such as depression, anxiety, bipolar disorder, ADHD, psychosis, and related symptoms. By signing, you acknowledge that you understand the information and agree to proceed with treatment.

1. Medication Purpose
I understand that:
- Psychotropics act on the brain to influence mood, thoughts, emotions, and behavior.
- The specific medication(s) prescribed to me will be explained by my provider, including name, dosage, and intended effects.
- These medications may take several days to weeks to show full benefit.

2. Benefits
I understand that possible benefits include:
- Reduction or relief of psychiatric symptoms.
- Improved ability to function in daily life.
- Better participation in therapy and other treatments.

3. Risks and Side Effects
I understand that:
- All medications can cause side effects, which may be temporary or permanent.
- Possible side effects vary by medication but may include:
    - Drowsiness or insomnia
    - Weight gain or loss
    - Sexual side effects
    - Tremors, muscle stiffness, or movement disorders
    - Changes in appetite
    - Mood changes
    - Allergic reactions
- Rare but serious side effects may include:
    - Severe allergic reaction (swelling, rash, difficulty breathing)
    - Heart rhythm changes
    - Liver or kidney problems
    - Seizures
    - Suicidal thoughts or behaviors (especially in young people)

4. Pregnancy and Breastfeeding
I understand that:
- Some psychotropic medications may cause harm during pregnancy or while breastfeeding.
- I must inform my provider immediately if I am pregnant, planning pregnancy, or breastfeeding.

5. Alternatives
I understand that alternatives to medication may include:
- Psychotherapy
- Lifestyle modifications (diet, exercise, sleep hygiene)
- Support groups

- No treatment (with awareness of risks of untreated symptoms)

6. Responsibilities
I agree to:
- Take medications exactly as prescribed.
- Report side effects or concerns promptly to my provider.
- Avoid abruptly stopping medication without medical guidance.
- Attend follow-up appointments as recommended.

7. Confidentiality
I understand that:
- My medical information will be kept confidential under HIPAA regulations.
- Certain situations may require disclosure without my consent (e.g., imminent risk of harm, abuse reporting, legal requirements).

8. Right to Withdraw Consent
I understand that:
- I have the right to refuse or discontinue medication at any time.
- If I choose to stop medication, I will notify my provider to discuss safe discontinuation.

Consent
I have read (or had read to me) the above information about psychotropic medications.
I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction.
I voluntarily consent to take the prescribed psychotropics as recommended by my provider at Luminox Healthcare Services, LLC.

Client Name: _____ **Date of Birth:** _____

Client Signature: _____ **Date:** _____