NOVA NEUROPSYCHIATRY, PLLC
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INFORMED CONSENT FOR PSYCHIATRIC TREATMENT

I am voluntarily and without undue influence providing informed consent to receive psychiatric treatment, specifically psychotropic medication treatment, as recommended and prescribed by Dr Alexandru Serghi, M.D.

I have received information describing the specific condition or diagnosis to be treated, the beneficial effects on that condition expected from the medication, the probable health and mental health consequences of not consenting to the recommended medication, the possible and probable clinically significant side effects and risks associated with the medication treatment, if any, and the reasons for the proposed course of treatment.

I have been given the opportunity to ask questions related to the proposed treatment plan.

I understand that I have the right to choose not to consent to initiation of the proposed medication treatment as recommended by Dr Alexandru Serghi, M.D.

I understand that I have the right to withdraw my consent for this treatment at any time, after consulting with Dr Alexandru Serghi, M.D.

The psychotropic medication(s) prescribed on this date by Dr Alexandru Serghi, M.D.:

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Patient’s Name

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Patient’s Signature

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Date