Cleveland Psychiatry Associates
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CONSENT FOR TREATMENT AND COORDINATION OF CARE

I give permission to clinicians at Cleveland Psychiatry Associates LLC to evaluate, coordinate and treat me, or my child for whom I am the legal guardian. I further authorize any tests, laboratory investigations, procedures and medications as deemed necessary and mutually agreed to by me. To facilitate coordination of care, I authorize release of medically necessary information to other clinicians at Cleveland Psychiatry Associates LLC as well as to my or my child's primary care physician(s).

I, (print patient name)_____understand the following:

- That it is my responsibility to ask all relevant questions to my satisfaction.
- That I have the authority to refuse all treatments and medications.
- That I will avail all opportunities to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.
- A less than 24 hours before the scheduled appointment cancellation or a no-show will be charged a $100 missed appointment fee.
- For new patients' first appointments, a no show or late cancellation will result in a full charge of the new patient fee.
- Please ask for our Office Policies or read them on our website www.clvpsych.com.

Patient Signature: _____ Date _____

Guardian Signature: _____ Date _____