Consent for Psychiatric Treatment

I hereby authorize Melody Medical Group P.C. to provide psychiatric treatment as explained to me. I authorize Nathan Skoller, MD and/or such assistants as may be requested by said physician to provide psychiatric treatment as explained to me. I understand that while this treatment may be beneficial, as with any treatment, there are inherent risks. During treatment, I will discuss personal issues which may bring up uncomfortable emotions such as anger, guilt, and sadness. The benefits of treatment can far outweigh this discomfort and can lead to benefits such as improved personal relationships and reduced feelings of emotional distress. During treatment, recommendations to take medications, undergo procedures, obtain testing, and/or engage in therapy may be made if clinically appropriate. I acknowledge that no warranty or guarantee has been made as to the results of this treatment. I understand that any aspect of this consent form that I do not understand can and will be explained to me in further detail by asking my physician.

CONFIDENTIALITY: I understand that discussions between myself and my physician as well as any records are confidential with the exceptions noted below and in the Notice of Privacy Practices provided to me. No information will be released without my written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following: abuse of any other person, sexual exploitation, AIDS/HIV infection and possible transmission, criminal prosecutions, child custody cases, suits in which the mental health of a party is in issue, situations where the physician has a duty to disclose, or where, in the physician's judgment, it is necessary to warn or disclose, a negligence suit brought by the client against the physician, or the filing of a complaint with the licensing or certifying board. If I have any questions regarding confidentiality, I will bring them to the attention of my physician. By signing this Information and Consent Form, I am giving consent to the undersigned physician to share confidential information with all persons mandated by law and with the agency that referred me and the insurance carrier responsible for providing my mental health care services and payment for those services. I am also releasing and holding harmless the

undersigned physician from any departure from my right of confidentiality that may result.

DUTY TO WARN/DUTY TO PROTECT: If my physician believes that there is imminent risk of harm to myself or to another human being, I understand that my physician is required by law to contact medical or law enforcement personnel to prevent harm to me or another person, and may contact the person in danger.

CONSENT TO TREATMENT: Psychiatric treatment as stated, including the possible risks, complications, options, and expectations have been explained to me or my representative and consent for treatment is thus given as noted by signature. I understand that this psychiatric treatment is not without risks. I hereby acknowledge and agree that I will be personally responsible for paying the financial charges for those services. I am voluntarily agreeing to receiving mental health assessment, treatment, and services for me, and I understand that I may stop such treatment or services at any time.