Vital Minds Psychiatry LLC.

Informed Consent for Psychotropic Medications

By electronically signing this form, I verify that I voluntarily consent to receiving prescriptions from my provider for psychiatric medications as a part of my treatment with Vital Minds Psychiatry, LLC. I also confirm that I understand and voluntarily agree to the following.

1. I am entitled to receiving information about the medications I am prescribed.
2. I understand that information about my medications will be provided in oral, and electronic form by my provider before any medication is prescribed.
3. I understand that my prescriber of record will also ask me to provide voluntary verbal consent for any new medications, medication changes, and/or the discontinuation of medications before they are ordered. Such verbal consent confirms that information about my medications was explained to my satisfaction and will be binding as noted in my health record.
4. I understand psychotropic medications may have risks that include side effects, age-related risks, rare and potentially life-threatening side effects, as well as fetal risk for pregnant women. If I am a woman and have a possibility of pregnancy, I understand that I must tell my provider immediately to assess the risks and benefits of taking my prescribed medications.
5. I acknowledge my right to refuse any medication dose or withdrawal my consent for medications at any time.
6. I understand that having psychotropic medications prescribed by a non- Vital Minds Psychiatry, LLC. provider, except in a psychiatric urgency or emergency that warrants it, may result in immediate discharge and end my patient-provider relationships with Vital Minds Psychiatry, LLC. Upon such discharge, I understand that I will be given a list of alternate providers in my area from which I may choose for the continuation of my psychiatric care. I understand I am responsible for making those appointments immediately to prevent gaps in my care.
7. I understand that I can print this consent form at will.

Patient Name (Last, First)

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Patient Date of Birth

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Patient Signature to Signify Agreement with Terms

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