CONSENT TO TREAT

I, _____(the patient), authorize and request that Rachel Ross, M.D. (the physician) provide evaluation and treatment services which now, or during the course of my care , are advisable. The frequency and type of treatment will be decided between the physician and the patient. Initial psychiatric evaluations last for 90 minutes. An initial evaluation does not automatically establish an ongoing doctor-patient relationship and the physician reserves the right to not enter into an ongoing doctor-patient relationship based on their clinical judgement, in which case alternate treatment resources may be provided to the patient as appropriate. Follow up visits may vary in length: 30 minutes for medication management/brief therapy and 30-60 minutes for full therapy/medication management sessions. I understand that there is every hope that I will benefit from treatment but there is no guarantee that this will occur. I recognize that modern psychiatric medication treatment includes risks of common side effects and the possibility of serious harm or even the remote risk of death. I understand that treatment safety and benefit will be maximized with consistent follow up, and following of the physician recommendations, and that no further treatment or a trial off of medications is always a treatment option.

The policies and practices of Rachel Ross, M.D. are further described in the document, "Office Policies and Practices 2020." You have been given a copy of "Office Policies and Practices 2020" for review.

The purpose of this Consent to Treat form is:

1. For you to give your consent, in writing, to receive services from Rachel Ross, M.D.;
2. For you to understand and acknowledge the following:
    - That my decision to seek services from Rachel Ross, M.D. is voluntary. I have read the document entitled, "Office Policies and Practices 2019," and I understand the policies and procedures detailed in it. I agree to adhere to the policies and procedures detailed in this document and I consent to receive services from Rachel Ross, M.D.
    - That I have been fully informed about the nature, risks and benefits of treatment, and the availability of treatment options.
    - That I have had the opportunity to have all questions answered to my satisfaction.
    - 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 Rachel Ross, M.D. may receive professional consultation with regard to patient care. I further consent to have Rachel Ross, M.D. disclose my private information to consultants and colleagues for the purpose of professional consultation.

Please sign below to indicate that you agree with all statements above and that you consent to receive services from Rachel Ross, M.D.

Printed Name _____

Signature _____Date _____