Mind Rejuvenation, LLC
Iftikhar Hussain, MD
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PH: (918) 340-6460
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4922 E 73rd St, Tulsa, OK 74136

CONSENT FOR TREATMENT AND PSYCHOTROPIC MEDICATION AGREEMENT

Name: _____DOB: _____ Date: _____

I. CONSENT FOR PSYCHIATRIC EVALUATION AND TREATMENT

I, the undersigned, voluntarily request and consent to psychiatric evaluation, diagnosis, and treatment by the undersigned Provider. I understand that mental health treatment is a collaborative and evolving process that may include, but is not limited to, psychiatric assessment, medication management, psychotherapy referrals, diagnostic testing, and coordination of care.

I acknowledge that no guarantees or warranties, express or implied, have been made regarding the outcome of treatment, symptom resolution, or duration of care.

II. PSYCHOTROPIC MEDICATION MANAGEMENT & INFORMED CONSENT

If psychotropic medications are prescribed, I acknowledge, understand, and agree to the following:

1. Risk–Benefit Analysis

I understand that all medications involve a balance between potential therapeutic benefits and potential risks, including side effects, allergic reactions, and unforeseen complications. My Provider has discussed these risks with me to a reasonable extent; however, I acknowledge that I am responsible for reviewing the manufacturer's medication guide provided by the pharmacy.

2. Assumption of Risk

I understand that psychotropic medications may cause side effects ranging from mild to severe, including but not limited to:

- Dry mouth, sedation, insomnia, dizziness
- Weight or appetite changes
- Sexual side effects
- Mood changes, agitation, or emotional blunting
- Metabolic syndrome, cardiac effects, liver or kidney effects
- Movement disorders, including Tardive Dyskinesia
- Rare but serious reactions such as Stevens-Johnson Syndrome, Neuroleptic Malignant
- Syndrome, serotonin syndrome, or suicidal ideation

I voluntarily assume these risks and agree to proceed with treatment.

3. Strict Adherence

I agree to take all medications exactly as prescribed. I will not alter the dosage, frequency, or method of administration, nor will I discontinue medication without medical supervision. I understand that abrupt discontinuation may result in withdrawal symptoms, symptom rebound, or clinical destabilization.

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4. Mandatory Monitoring

I understand that certain medications require ongoing monitoring, including but not limited to laboratory testing, EKGs, vital signs, weight, or other diagnostic measures. I agree to complete required monitoring within the requested timeframe. I understand that failure to comply may result in delayed refills or discontinuation of medication prescribing.

III. CONTROLLED SUBSTANCES & PRESCRIPTION MONITORING PROGRAM (PMP)

For any controlled substances (Schedule II–IV), including stimulants, benzodiazepines, or sedative-hypnotics, I agree to the following:

Exclusivity: I will obtain psychiatric medications from one prescribing provider and one pharmacy only. State Monitoring: I consent to the Provider's regular review of the state Prescription Monitoring Program (PMP) database.

Security: I am responsible for safeguarding my medications. Lost, stolen, or damaged prescriptions for controlled substances will not be replaced.

Compliance: Evidence of misuse, diversion, or noncompliance may result in immediate discontinuation of controlled substance prescribing.

IV. DISCLOSURE & INTERACTION RISKS

I agree to fully disclose all substances I am using, including prescription medications, over-the-counter drugs, alcohol, tobacco, cannabis, herbal supplements, and illicit substances.

I understand that failure to disclose substance use or medication changes significantly increases the risk of dangerous drug interactions and adverse outcomes.
I agree to notify the Provider promptly of:

- New medications or supplements
- Significant changes in medical or mental health status
- Pregnancy, plans for pregnancy, or breastfeeding

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V. CONFIDENTIALITY & LEGAL LIMITS

I understand that my health information is protected under HIPAA. However, I acknowledge that the Provider is a Mandated Reporter, and confidentiality may be breached as required by law under the following circumstances:

- Reasonable suspicion of child, elder, or dependent adult abuse or neglect
- Clear and imminent risk of serious harm to myself or others
- Receipt of a valid court order, subpoena, or other lawful mandate

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VI. TERMINATION OF CARE

I understand that the provider–patient relationship may be terminated by either party. Provider-initiated termination may occur for reasons including, but not limited to:

- Noncompliance with the treatment plan or medication agreement
- Failure to complete required monitoring or follow-up
- Misuse or diversion of medications
- Threatening, abusive, or disruptive behavior toward staff or the practice

Termination will occur in accordance with applicable laws and ethical guidelines, including reasonable notice and transition planning when appropriate.

ACKNOWLEDGMENT OF UNDERSTANDING & CONSENT

By signing below, I certify that:

- I have read and understand this document in its entirety
- The risks, benefits, and alternatives to treatment have been explained to me
- I have had the opportunity to ask questions and received satisfactory answers
- I voluntarily consent to psychiatric treatment and psychotropic medication management as clinically indicated

Patient / Legal Representative Signature: _____

Provider Signature: _____ Date: _____