TrilliumPsychiatry, PLLC.

Igor Epstein, DO
Psychotherapy and Psychopharmacology
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CONSENT TO TREATMENT

I, _____, Birth Date ____/____/____, am a patient of Dr. Igor Epstein.

Dr. Epstein has informed me that he recommends that I receive psychotherapy and/or the medication for the treatment of my illness or problems. He has informed me of the nature of the treatment and has explained to me the benefits as well as the risks including potential side effects. I am aware that Dr. Epstein might request certain laboratory tests or diagnostic procedures as part of treatment plan. He also has discussed the alternative approaches to care including receiving no care at all.

I understand that although Dr. Epstein has explained the most common side effects of proposed treatment to me, there may be other side effects, and that it is my responsibility to promptly notify Dr. Epstein if there are any unexpected changes in my condition or if any problems arise relating to my treatment.

I understand that I am not compelled to take the medication and/or engage in psychotherapy and that I may decide to stop it at any time. It is my responsibility to notify Dr. Epstein if I do decide to terminate treatment.

I also understand that although Dr. Epstein believes that this medication and/or psychotherapy will help me, there is no guarantee that me condition will improve.

On this basis I authorize Dr. Epstein to provide psychotherapy and/of prescribe medication at such intervals he deems advisable.

I understand that I may receive a copy of this consent.

_____ _____
Patient's Signature Date

_____ _____
Witness (if applicable) Date