

Lily Health and Wellness Center

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Informed Consent for Psychotropic Medications

This document explains your rights, responsibilities, and important information related to the use of psychotropic (psychiatric) medications as part of your treatment at **Lily Health and Wellness Center Telepsychiatry**. Please review this information carefully before signing.

Consent to Treatment

By electronically signing this form, I acknowledge that I voluntarily consent to receiving prescriptions for psychotropic medications from my provider as part of my psychiatric treatment with Lily Health and Wellness Center. I understand and agree to the following:

Patient Rights and Medication Education

- I have the right to receive clear and sufficient information about any medication prescribed to me.
 - I understand that information regarding prescribed medications will be provided by my provider in verbal and/or electronic form prior to initiation.
 - I understand that my prescriber will obtain my voluntary verbal consent before initiating any new medication, changing a dose, or discontinuing a medication. This verbal consent will be documented in my medical record and will serve as confirmation that the information was explained to my satisfaction.
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Risks and Considerations

- I understand that psychotropic medications may involve risks, including but not limited to side effects, age-related risks, rare but potentially life-threatening reactions, and risks during pregnancy.
 - If I am pregnant or may become pregnant, I understand that I must notify my provider immediately so that the risks and benefits of treatment may be appropriately evaluated.
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Right to Refuse or Withdraw Consent

- I understand that I have the right to refuse any prescribed medication or to withdraw my consent for medication treatment at any time.

Prescribing Restrictions

- I understand that receiving psychotropic medications from a provider outside of Lily Health and Wellness Center—except in cases of psychiatric emergency or medical necessity—may result in immediate discharge from care and termination of the patient-provider relationship.
- In the event of discharge, I understand that I will be provided with a list of alternative providers for continuation of psychiatric care.
- I acknowledge that I am responsible for promptly scheduling follow-up care with an alternative provider to avoid interruption in treatment.

Access to This Consent

- I understand that I may print or obtain a copy of this consent form at any time upon request.

Acknowledgment and Signature

By signing below, I confirm that I have read, understand, and voluntarily agree to the terms outlined in this Informed Consent for Psychotropic Medications.

Patient Name (Last, First): _____

Date of Birth: _____

Patient Signature: _____

Date: _____