Axial Psychiatric Services
Email: Info@AxialPsychiatricServices.com *Ankit Parmar, M.D, M.H.A.*

MEDICATION CONSENT FORM

I am providing consent for (Patient's name) _____, Age _____
for treatment with psychiatric medications discussed during my clinic visit.

I understand the following:

☐ That I have been fully informed about the nature of the treatment, the risks and benefits, and all the other available treatment options.

☐ That I have had the opportunity to have all questions answered to my satisfaction.

☐ That this consent is given voluntarily.

☐ 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 withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Signature: _____ Date: _____

Name: _____

Relationship: ◉ Patient Him/Herself ○ Parent ○ Legal Guardian

_____ _____
Ankit Parmar, M.D., M.H.A. Date

Location: 6730 Horizon Rd, STE C, Rockwall, TX 75087
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