THE RETREAT AT PONTE VEDRA BEACH
Consent for Treatment

Office:	The Retreat at Ponte Vedra Beach			
	35 Executive Way, Suite 104, Ponte Vedra Beach, FL 32082			
	Phone:	(904) 335-3252	Fax:	(904) 562-3395

The undersigned patient or responsible party (parent, legal guardian or conservator) for _____ (patient) consents to, and authorizes services, by Dr. Theresa Randazzo-Burton, MD / Dr. Elizabeth Winings, DNP (circle one).

These services may include Psychiatric assessment and management, psychopharmacology with or without psychotherapy, ordering and interpreting laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive verbal or written informed consent regarding the risks and benefits of medication recommendations and will be required to sign an agreement when novel medication prescription is issued
3. Have the opportunity to have all questions answered to my/our satisfaction.
4. That this consent is given voluntarily.
5. That I am legally competent and have the authority to provide consent for treatment.
6. Receive a copy of this consent.
7. That I have the right to withdraw my consent for this treatment at any time.
8. That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Printed Name Signature of Patient Date Signed

Printed Name Signature of Parent, Legal Guardian or Conservator Date Signed

Signature of Witness (if appropriate) Date Signed