VIRGINIA
INTEGRATIVE
PSYCHIATRY, PC

Sudhir Nagaraja, DO MS

Board Certified Psychiatrist
Board Certified Integrative Medicine

INFORMED CONSENT FOR TREATMENT

Dr. Nagaraja provides Psychiatric evaluation and treatment services. The evaluation includes taking a complete history, if necessary performing an exam, and providing a diagnosis. Treatment may include: psychotherapy, diet plans, medications, holistic treatments, referral to other health providers.

Your health records are confidential and privileged. However, there are instances in which confidential information can or must be released without your consent. These instances include, but are not limited to the following:

- Abuse. If there is suspected child abuse, elder abuse, or dependent adult abuse.
- Serious threat to others. A situation in which serious threat to a reasonably well-identified victim is communicated to Dr. Nagaraja or a member of his staff.
- Serious threat to self. When threat to injure or kill oneself is disclosed by you.
- Insurance. When you are required to sign a release of information by your health insurance.
- Children. Clients under 18 do not have full confidentiality from their parents.
- Electronic communication. If you authorize electronic communication, including email. All electronic communication risks a compromise of confidentiality.

Please refer to "Privacy Practices- Dr Nagaraja" for full details regarding Protected Health Information.

I, _____, do voluntarily consent to psychiatric treatment provided by Sudhir Nagaraja, D.O., hereafter referred to as Dr. Nagaraja, for myself or the patient listed above for whom I am the legal guardian and have the legal authorization to consent for treatment.

I understand that I am consenting and agreeing only to the services that Dr. Nagaraja provides within the scope of his license, certification, and training.

I understand that psychiatry is not an exact science and no guarantees are made as to specific outcomes. Services are provided according to standards of care and/or practice guidelines. Dr. Nagaraja can not guarantee that a specific medication will be prescribed.

I understand I am an active participant in this treatment and that I share the responsibility for the treatment process, including setting goals and terminating treatment.

I understand I have the right to revoke this consent in writing and terminate services with Dr. Nagaraja at any time.

I have read and understand the information on this sheet. My signature indicates my informed consent with Dr. Nagaraja.

Print name	Signature	Relationship to patient	Date