Consent for Care and Treatment

I agree and consent to participate in the mental and behavioral health services offered by Dr. Issa P. Bagayogo and the Olive Space Psychiatry LLC. You have the right as a patient to be informed about your condition and the recommended course of treatment. This is important so that you have enough information to make the decision whether or not to undergo treatment after knowing the risks involved. Although at this point in your care, no specific treatment plan has been recommended, this consent form is simply to obtain your permission to perform the necessary evaluation to identify the most appropriate treatment course. Therefore, this consent provides Dr. Issa P. Bagayogo and the Olive Space Psychiatry LLC your permission to perform the reasonable and necessary assessment, evaluation, examination and testing including laboratory and drug toxicology testing.

By signing below, you are indicating that (a) you have reviewed a copy of the Olive Space Psychiatry privacy policy, practice policies and procedures and the HIPAA notice form; (b) you are agreeing only to those services that Dr. Issa P. Bagayogo is qualified to provide within the scope of his license, certification and training; (c) you are consenting to receiving treatment at this office; (d) this consent is continuing in nature even after the initial diagnosis and treatment recommendation has been made; and (e) the consent will remain fully effective until it is annulled in writing. You have the right at any time to discontinue care at the Olive Space Psychiatry LLC.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Name of Patient or Personal Representative: ______________________________

Signature of Patient of Personal Representative: ____________________________

Relationship to Patient: ____

Date: __________________

Witness's name: ___________________________________

Witness' Signature: ________________________________ Date: __________