Fort Bend Psychiatry

Dr. Shannon L. Sniff, M.D., PLLC
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Consent for Evaluation and Treatment

Name of Patient: _____ Date:_____
(Print Patient Name)

Name of Parent or Guardian (if patient is a minor): _____
(Print Name)

I acknowledge that I am voluntarily seeking medical evaluation by Dr. Shannon L. Sniff, M.D., PLLC. I understand that as a part of that process, I may be recommended to receive diagnostic testing, psychological testing, psychotherapy and/or medication management. I understand that I have the ability to decline the aforementioned services at anytime, but this may affect my treatment process and outcome.

The following types of medications are commonly prescribed to treat psychiatric conditions:

- Antidepressants
- Antipsychotics
- Anxiolytics
- Stimulants
- Mood Stabilizers

I understand that refusal to comply with Dr. Sniff's recommendations could result in grounds for termination of the patient – physician relationship. I also understand that I have the right to terminate the relationship at anytime.

Signature: _____ Date: _____

Witness: _____ Date: _____