New Garden Psychiatry
2016 New Garden Road, Suite C
Greensboro, NC 27410

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CONSENT FOR TREATMENT

I am an independently practicing professional. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Janardhana Jonnalagadda, M.D. These services may include medication therapy, laboratory tests, diagnostic procedures and other appropriate 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 a copy of this consent.
3. Withdraw this consent at any time.

______________________________________ ________________
Signature of Patient Date Signed

______________________________________ ________________
Signature of Parent, Legal Guardian or Conservator Date Signed

______________________________________ ________________
Signature of Witness (if appropriate) Date Signed