BAY HILL PSYCHIATRIC ASSOCIATES LLC

6068 South Apopka Vineland Road, Suite 3, Orlando, FL 32819
407-903-9696

Syeda N. Sultana, M.D.
Child, Adolescent & Adult Psychiatry
BOARD CERTIFIED

AUTHORIZATION FOR CARE AND TREATMENT

Patient: ______________________________________ Date of Birth: ________________

Therapist: _ Syeda N. Sultana, M.D

1. I recognize that a condition exists requiring psychiatric/psychological care and do hereby voluntarily consent to such care, medical care and treatment and diagnostic procedures by Bay Hill Psychiatric Associates LLC (Medical professional staffs, employees & agents) or as deemed necessary.
2. I hereby authorize the physician assigned, as provided by law, to furnish psychiatric/psychological care or therapy, including administration of psychiatric medication.
3. I am aware that the practice of medicine, including psychiatry and psychology, are not exact sciences, and **I acknowledge that no guarantees have been made to me for a specific medication, as to the result of diagnostic procedures, medical procedures, treatments, examinations or care undertaken. The Doctor may Order Laboratory Blood, Urine, Drug test, Nero-psychological evaluation, Cardiac test before prescribing any medication. I agree to abide by the Doctors instruction. Any failure constitute removal of the patient from Bay Hill Psychiatric Associates.**
4. The contents of this form have been fully explained to me and I have been given the opportunity to ask questions. Any questions which I have asked have been answered to my satisfaction. I certify that I understand the contents of this form and that all blanks have been crossed out or filled in.

I UNDERSTAND THAT I AM ENTITLED TO AN EXACT COPY OF THIS AGREEMENT.

____ ____________________
Signature of Patient Date

____ ____________________
Witness Date

Signature of Parent of if Patient under is 18 years of age this form has been filled out and explained to the person whose signature appears by:

____ ____________________
Signature of Parent Date

____ ____________________
Witness Date