Jillan Cantor Sackett, MD. MS.

Synergy Psychiatry VT

Shelburne VT

**CONSENT FOR TREATMENT/Termination of Care**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**name, DOB**) hereby agree and give my consent to any examination, interviewing, medication, psychotherapy, or counseling that psychiatrist or therapist may deem necessary or advisable. It is understood that this consent may include psychological testing, individual psychotherapy, group therapy, family therapy, medication, and other related treatments if these are considered necessary.

I am aware that my psychiatrist may terminate care at any time and will provide me with three months of medications (if appropriate and safe as deemed by said psychiatrist) in order for me to find time to find another provider. My psychiatrist will try to assist me in finding another care provider, but cannot guarantee this as there is a scarcity of providers in our region.

I understand I may terminate treatment at this center at any time by informing my therapeutic team of such intent. I have read this document and understand and consent to this.

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_