Consent for Treatment – Sage Elevate

Patient Name: _____
Date of Birth: _____
Date: _____

Express and Informed Written Consent:
Treatment requires express and informed written consent under Florida law pursuant to Florida Statute §916.107, which means for the right of the patient to be fully informed and to make a voluntary decision. The medication will not be used as a chemical restraint, which is explicitly prohibited pursuant to Florida Administrative Code, Rule 65C-35.002(4), which strictly forbids the use of medication as a chemical restraint.

Purpose of Treatment:
I understand that I am receiving a **behavioral health medication by injection** as part of my treatment plan. The purpose of this medication is to help manage symptoms such as mood changes, anxiety, psychosis, or other behavioral health concerns.

Nature of Treatment:
I have been informed that:

- My treatment may involve **long-acting injectable (LAI) medications** administered in a muscle or under the skin.
- These medications release slowly over time and cannot be quickly removed from my body once given.
- My provider has explained the name of my medication, its purpose, how it will be given, and how often it is required.
- My provider has explained whether the medication is experimental or carries unreasonable risks, and I confirm that such risks have been discussed with my provider.
- My provider has explained alternative treatment options, which were considered or discussed prior to receiving this behavioral health medication by injection.
- My provider has reviewed with me my medical history for contraindications before prescribing this behavioral health medication by injection.
- My provider has explained my right to refuse treatment.

Potential benefits may include:

- Better control of symptoms.
- Reduced need for daily medication.
- Improved treatment consistency.

Possible risks and side effects may include (but are not limited to):

- Pain, redness, swelling, or bruising at the injection site.
- Allergic reactions.
- Weight changes, changes in mood or energy.
- Movement-related side effects (such as muscle stiffness, tremors, or restlessness).
- Changes in blood sugar, cholesterol, or hormones.
- Rare but serious reactions (provider will discuss specific risks for my medication).

My Responsibilities:
I agree to:

- Inform my provider of any side effects, concerns, or new health conditions, as soon as possible and before each treatment, which is critical to my ongoing treatment and care.
- Keep my scheduled appointments or notify the clinic if I cannot attend.
- Follow my treatment plan as discussed with my provider.
- If I experience a serious reaction or medical emergency, I understand that I should call 911 or go to the nearest emergency department. For non-emergencies, I will contact Sage Elevate at 813-683-5963.

Questions:
I have had the chance to ask questions about my medication, its risks, and alternatives. My questions have been answered to my satisfaction.

Consent:
By signing below, I acknowledge that I:

- Understand the purpose, benefits, risks, and alternatives of my treatment.
- Consent to receive behavioral health injections as part of my treatment plan.
  Understand that I may withdraw or refuse my consent at any time, which may affect my treatment.

Provider attestation:

- All of these disclosures, including the medication name, purpose, dosage, route, frequency, alternatives, risks were reviewed with the patient, and that the patient's understanding was confirmed. **Initial by Provider**.

I confirm that I have read and understood this consent form, that I have had the opportunity to ask questions, and that I am signing voluntarily.

Patient Signature: **Date:** _____

Provider Signature: **Date:** _____

Witness Signature: **Date:** _____