CONSENT FOR TREATMENT

I request possible treatment by Theresa Cerulli, M.D. for me and/or my child. I understand that the treatment is a specialized service and that I/my child must have a primary care doctor for standard medical and preventative care. I agree to see my/my child's primary care physician for regular monitoring and for preventative measures (i.e. immunizations, complete physicals, rectal exams and/or colonoscopy, EKG, mammograms, pelvic/breast exams, PAP smears, and prostate exams, etc.) at least on a yearly basis. I understand that there are general guidelines for these preventative measures and agree to discuss the potential need for these screening measures on a regular basis with my/my child's primary care physician. I understand that it is not the responsibility of Theresa Cerulli, M.D. to arrange for these preventative measures, but agree to comply if either of them suggests that my/my child's PCP perform such measures.

We may employ a number of natural and pharmaceutical treatments that may not fall under the strict guidelines of conventional medicine as defined by those health care methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine practice, based upon medical training, experience and review of the peer reviewed scientific literature and that some of the treatments may be considered complementary, integrative, alternative, non-conventional or non-standard. You have the right, as a patient/parent, to be informed about your/your child's condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedure to be used so that you make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved.

I voluntarily request Theresa Cerulli, M.D. and such associates, technical assistants and other health care providers as they may deem necessary, to treat my/my child's condition, which may include but not limited to Attention Deficit Hyperactivity Disorder (ADHD and ADD), anxiety disorders, mood disorders such as but not limited to depression and dysthymia, and learning difficulties.

I understand that my/my child's doctor will direct treatment based on signs, symptoms, neuropsychological assessments, and laboratory results. I understand that it is not always possible to give a definitive diagnosis. I understand, consent and authorize that I/my child may be treated conventionally and/or with alternative, herbal and nutritional therapies, off-label use of pharmaceuticals, behavior modification, individual and group therapies, and coaching. I realize that just as there may be risks and hazards in continuing my/my child's present condition with or without conventional medical treatments and procedures, there are also risks and hazards related to the performance of the alternative, integrative, complementary non-conventional or nonstandard procedures and treatments planned for me/ my child. I agree to ask about the risks associated with any treatment and discuss this with the treating doctor before any treatment is begun and will not agree to treatment unless the risks have been explained to me to my satisfaction and I understand those risks.

CONSENT FOR TREATMENT

Licensed behavioral health counselors are trained to administer complimentary treatment interventions such as coaching and Cogmed working memory training. I understand that such complimentary services do not constitute engagement in the practice of psychotherapy, or a therapeutic treatment relationship with the administrating clinician. If issues arise that are best dealt with in a therapeutic context, I am aware that my/my child's clinician will recommend a formal behavioral health assessment in order to render clinical judgment and treatment planning as a licensed mental health provider.

I agree to comply with requests for ongoing testing to assure proper monitoring of my/my child's treatments. I agree to immediately report to Theresa Cerulli, M.D. any adverse reaction or problem that might be related to my/my child's treatment. I understand that along with the benefits of any medical treatment or therapies, there are both potential risks and complications to treatment, as well as, to not being treated. This may include worsening of current symptoms, development of new symptoms and undesirable interactions between various treatments, including conventional, complementary, integrative, alternative or "non-standard." I agree that I have received sufficient information regarding these risks and benefits; have had all my questions sufficiently answered, and agree to proceed with treatment and to comply with recommended dosages. Furthermore, I have not been promised or guaranteed any specific benefit from the administration of therapies or treatment and no warranty or guarantee has been made regarding results of treatment.

I have been given an opportunity to ask questions about my/my child's condition, conventional treatment, integrative and complementary treatment, alternative forms of treatment, risks of treatment, risks of non-treatment, procedures to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo/allow my child to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits.

I have been informed that many insurance companies may not pay for some therapies; and therefore agree to be responsible for all laboratory, pharmacy, therapies, nutraceuticals and office visit charges, with the full understanding that I may not be reimbursed by my insurance company. Theresa Cerulli, M.D. is not responsible for an insurance company's denial of payment.

Print Name of Client / Custodial Parent	**Client /Custodial Parent Signature**	**Date**