Sheryl M. Hakala, M.D., P.A.

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Phone: (813) 503-7404

I understand that the first appointment with this psychiatrist is for the purpose of evaluating, diagnosing and treatment planning of my presenting complaint I understand that this initial evaluation my range from 60-90 minutes and may require future sessions or referral to another professional, depending on the diagnosis and specialty of the psychiatrist.

I understand that no medications are without risk for untoward events, and that there are rare and fatal side effects that can occur with any medication. I understand that it is my responsibility *to* notify my primary care provider then Dr. Hakala immediately if my child or I have any new physical ailments or side effects. I also understand that during my treatment, if I am prescribed more than one medication at a time, there may be possible drug interactions. I also understand that if I am prescribed a medication for my child, it will more than likely not have a black box warning for the use in children or not be FDA approved for the use in children. Most medications prescribed by psychiatrists also have a risk for suicidality. If my child or I am suicidal, it is my responsibility to notify Dr. Hakala personally. If I am unable to speak to Dr. Hakala immediately, it is my responsibility to obtain safe transportation to the nearest ER which may entail calling 911. Most medications prescribed by psychiatrists could cause possible harm to a fetus. It is my responsibility to ensure that my child or I do not become pregnant on psychotropic medications. I understand that any of the following methods: tubal libation, vasectomies, barrier methods, RID's, and oral contraceptives are not without risk of pregnancy.

I understand that Dr. Hakala makes every effort to be available twenty four hours a day, but my ability to reach her may be dependent upon and limited by the function or dysfunction of electronic devices, such as cell phones going out of range or satellites not working properly. I understand that if a disaster occurs that Dr. Hakala will make every attempt to be available by phone, but this may not be possible due to the nature of disasters. If I sin unable to reach her, I will find safe transportation to the *eeriest* ER. If Dr. Hakala has any medical procedures done, she will not be available, and I will go to the ER for treatment at those times.

In the process of my treatment/evaluation, I allow this psychiatrist to discuss ray case with my therapist, previous psychiatrist, family doctor and any other professional directly involved in my treatment. I understand that in the course of my evaluation/treatment Twill be given a diagnosis. I understand that I am fully liable for these appointments. That if I make an appointment and fail to call or show, I will be charged the frill fee fur the appointment time. I also understand that this fee will not be reimbursed by my insurance. This fee must be paid out of pocket by me, before *another* appointment can be made. I also understand that if legal action has to be taken against I for the collection of any unpaid fees, said balances will be sent to a collection agency after *90* days of attempted collections. I also understand that I will be held responsible for any legal fees incurred in this process.

I agree not to call Dr. Hakala as a witness in any litigation or legal proceeding, nor request or use any of her records or notes for the purpose of litigation. Should anyone seek to compel Dr. Hakala to provide information in a court proceeding or elsewhere, I agree in advance that I will compensate her in advance at her hourly court rate of $950 per hour including travel and preparation, and costs of all legal services which Dr. Hakala might choose to employ to defend the confidentiality/privilege of *these* sessions and of her notes.

I have read the above policies and fully understand them. In the case that I did not understand some of the information stated in this document, I have asked for an explanation. No guaranties or assurances have been made to me concerning the results of these services. This is a release of any liability to Sheryl Hakala or Sheryl M. Hakala, M.D., P.A., from any decisions or actions that may or may not take place as a result of the evaluation, therapy, counseling, psychiatric treatment, or referral I receive. I understand that under HIPAA all my clinical information will be kept confidential. That the State of Florida affords privilege to patient's mental health service provided under a licensed professional.

_____	_____	_____/_____/_____
Signature of Patient	Name of Patient	Date
_____	_____	_____/_____/_____
Signature of Witness	Name of Witness	Date

If patient is a minor, parent or legal guardian must sign

Your signature constitutes a legal contract between you and Sheryl M. Hakala, M.D., P.A.