Jodie Skillicorn, DO

*395 Boston Mills Rd. Hudson, OH 44236*

*Phone: 330-715-9282 Fax:330 752-2541*

**Consent to Treat**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I voluntarily consent to outpatient care with Jodie Skillicorn, DO.

I understand Jodie Skillicorn, DO uses an integrative psychiatry and mental health

approach with limited use of medications.

I understand that the care I receive from Jodie Skillicorn, DO may be considered non-

conventional. Such services are commonly referred to as integrative, complementary,

alternative or holistic services. This may include nutritional and supplement

recommendations, mindfulness and breathing practices, energy psychology and qi qong practices, guided imagery, EMDR, hypnotherapy and other mind-body approaches to care. While many of these techniques have been long practiced and researched and found to be effective, some are still considered “investigative” or “experimental” by some in the psychiatric field. The treatment plan is a collaborative effort and I recognize it is my responsibility to let Dr. Skillicorn know which approaches I would like to try and those with which I do not feel comfortable. I recognize it is entirely my choice. By accepting these treatments, I agree to accept the risks explained to me about these treatments.

I have read and understand the foregoing and understand that it is my responsibility to discuss

any concerns I have about any and all parts of my treatment plan. I understand the nature of

these health care methods and consent to counseling and treatment.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_