The TMS Center of New Jersey

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Consent for Treatment

I, _____ consent to the rendering of medical care, which may include psychotherapy, medication or neuromodulation treatment of mental illness and any such treatment as David Sikowitz MD deems necessary. I understand that I am not compelled to engage in psychotherapy, take medication and/or participate in brain stimulation and I may decide to stop it at any time. I understand that it is my responsibility to promptly notify David Sikowitz MD if there are any unexpected changes in my condition and/or if any problems arise relating to my treatment and/or if I do decide to terminate treatment. I also understand that although David Sikowitz MD believes that psychotherapy, medication and/or neuromodulation will help me, there is no guarantee that my condition will improve or as to the results that might be expected. I understand that I have the right to consent or to refuse consent, to any proposed procedure or therapeutic course.

_____ _____

Patient or Patient's Legal Representative Signature Legal Representative's Name & Relationship

_____

Date