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INFORMED CONSENT FOR TREATMENT

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I hereby request that ______________________________ born _________________ and
Participant Name Date of Birth
residing at ____
Street Address City State Zip Code
____________________________ be accepted for psychiatric, mental health, or alcohol
Telephone Number
and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from____.
Provider
2. I have been given information regarding my rights and responsibilities as a participant.

3. I have been given information regarding the limits of confidentiality of my records.

4. I have been given information regarding the cost of services from ______________________________. I understand that I responsible to pay a copay and
Provider
that it is payable each time I come from treatment.
5. I understand that I may address any concerns or grievances with my therapist or any other insurance company representative at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

____ ______________________________
Signature of Participant or Legal Consenter Date

____ ______________________________
Witness Date

MINOR (Emancipated Minors Only):
Informed Consent for Treatment

Due to the following reason ____,
Reason
I have the legal capacity under applicable _________________________ law to apply for
State
consent to such treatment and services mentioned in this form, without parental consent.

____ _______________________
Signature of Participant Date

____ _______________________
Witness Date

PARENT OR GUARDIAN:

I, ____, do hereby state that I am the
Parent or Legal Guardian
Natural parent or legal guardian of the participant; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

____ _______________________
Signature of Participant Date

____ _______________________
Witness Date