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TREATMENT CONSENT

I/We hereby provide consent for ____
Patient's name

to receive treatment for ____
Disorder being treated

with the following treatment(s):

____

____

____

I/we understand the following:

- That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the alternative treatment options.
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

____ Date ______________
Patient signature*

____ Date ______________
Parent/legal guardian

____ Date ______________
Treatment provider