Whole Life Psychiatry

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CONSENT FOR TREATMENT

You have the right, as a patient, to be informed about your condition and the recommended medical or diagnostic procedures to be used so that you may make the decision whether or not to undergo any suggested treatment. This consent form is to obtain your permission to perform the evaluation necessary to identify appropriate treatment.

You have the right to discuss the treatment plan with your provider regarding the purpose, potential risks, and benefits of any treatment recommended by your provider.

I certify that I have read and fully understand the above statements and consent to treatment.

_____

Printed name of patient

_____

Signature of patient

Date: ___/___/___