# Consent for Treatment

I have read and been given a copy of the practice policies of Elizabeth Boswell, M.D., L.L.C. I understand the policies and give my consent for treatment to be provided by Dr. Boswell. I further understand that I am personally responsible for any ensuing charges made for services rendered. I also authorize Dr. Boswell to provide information regarding my evaluation and treatment to any physician or therapist who has referred me to Dr. Boswell.

Name printed

Patient signature Date