EMPATHIC RESONANCE, LLC

EMPATHY DRIVEN INDIVIDUALIZED & HOLISTIC CARE ©

ADULT, CHILD & ADOLESCENT PSYCHIATRIC CONSULTATIONS & SERVICES

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TREATMENT CONSENT FORM

I/we are providing consent for _____
Patient's name

to receive treatment for _____
Disorder(s) being treated

with the following treatment(s):

_____

_____

_____

My/our signature below indicates that I/we understand the following:

- That I/we have been fully informed about the nature of the disorder(s) being treated, the treatment, the consequences of accepting or refusing treatment, the risks and benefits of treatment, and the available 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

* If patient is a minor, signature may be required, depending on state law.