NK

Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • 305-985-2161 (P) • (305) 763-8475 (F)

Consent Form

I do hereby consent to take part in the treatment and/or Psychiatric Evaluation with Noam Koenigsberg M.D., board-certified Adult Psychiatrist licensed in Florida.
If the patient is a minor, I hereby give my consent as a parent/legal guardian for my child to participate in Psychotherapy and/or complete Psychiatric Evaluation by Dr. Koenigsberg. I understand that it is my sole responsibility to notify my child's other parent of these Psychiatric Services.

I am also in agreement that no guarantees have been made to me regarding treatment or evaluation. However I do understand that treatment benefits me as the patient.

I am aware that I have the right as the patient to terminate treatment with Dr. Koenigsberg at any time. My only obligation will be to pay my outstanding balance for the services I have previously received. I understand that under certain circumstances I may lose other services or may face other consequences if I stop treatment.

I am aware that the procedures utilized for diagnosing psychiatric disorders; selecting and implementing therapeutic interventions; and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychiatric Association and other professional organizations with adherence to diagnostic criteria in the Diagnostic and Statistical Manual (DSM).

I acknowledge that I have read, understand and agree with the statements within the Consent for Treatment as well as the rules and regulations for treatment under Dr. Noam Koenigsberg.

_____
_____
Patient Name (Print) Patient Date of Birth

_____
_____
Patient or Parent Signature Date

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Noam Koenigsberg, M.D. Signature Date