Lifetime Insight, LLC
440 Regency Parkway Dr., Suite 136
Omaha, NE 68114
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CONSENT FOR TREATMENT

Patient Name: ____________________________ Date: __________________________

Psychiatrists are governed by a code of ethics and by various laws and regulations. Treatment is strictly voluntary and you may choose to discontinue treatment any time you wish. Therapy sessions between a psychiatrist and patients are strictly confidential except under certain legally defined situations involving threats of self-harm, harm to others, and cases of past or present child abuse, elder abuse, or abuse of individuals. In those cases, psychiatrists are required by law to notify the proper authorities. I consent and authorize Lifetime Insight/Sarit Hovav, MD to provide me services that include psychotherapy, medication management, laboratory tests, diagnostic procedures, and other appropriate alternative therapies. I have the right to be informed of and participate in the selection of treatment modalities, receive a copy of this consent, and withdraw this consent at any time. I acknowledge that no guarantees have or will be made to me as to the results of treatments or examinations. I acknowledge that my obligation to pay the physician is not related to the success of the treatment accorded to the patient by the physician. I am also aware that I should ask the physician any question that I may have about my diagnosis, treatment, risks, or complications, alternative forms of treatments, and/or anticipated results of treatment. This consent remains valid until I choose to discontinue treatment.

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(Signature of Patient)

OR

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(Signature of guardian or authorized representative) (Relationship to patient)