Atlanta Stress Center
160 Clairemont Avenue, Suite 200
Decatur, GA 30030

TREATMENT CONSENT FORM

Your signature below indicates that you have read the treatment consent form, which contains information on psychiatric services, sessions, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting us, professional records, confidentiality, and practice status, and you agree to abide by its terms during our professional relationship.

Name of patient or guardian (print):____________________________Date:________

Signature of patient or guardian:______________________________ Date:________