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# TREATMENT CONSENT

I/we are providing consent for ______________________________________
Patient's name
to receive treatment for ____________________________________________
Disorder being treated
with the following treatment(s):

___

___

___

I/we understand the following:

- That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including _______ ____________________________________________________________ ____________________________________________________________
- 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.