TREATMENT CONSENT

I/We _______________ are providing consent for Beautiful Mind Clinic

to evaluate my psychological and emotional symptoms and personal history. In addition,

the history of the past and present treatment plan.

I/We understand the following:

- That I/We will be fully informed about the nature of the treatment, the risks and benefits, and the available treatment options after a complete psychiatric evaluation.
- That I/We will have 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's Signature*

____ Date __________________________
Parent/Legal Guardian

____ Date __________________________
Treatment Provider

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

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