TREATMENT CONSENT

I/We are providing consent for _____
Patient's Name

to receive treatment for _____
Treatment Disorder

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'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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