INFORMED CONSENT FOR TREATMENT

I _________________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided by Center for Family Guidance a behavioral health care provider. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I will inform any other individuals with whom I share custody arrangements for the patient of the initiation of treatment.

Signature (patients age 14 and above should sign this for minor)

_______________________________ Date_________________

Signature of Legal Guardian (if applicable)

_______________________________ Date_________________

Relationship to Patient (if patient is not providing signature)

____