silver|psychotherapy

INFORMED CONSENT FOR TREATMENT

2502 Urbana Pike Suite 203A Ijamsville, MD 21754
(240)415-8893, (240)444-8138 fax

I hereby request that_____born_____and residing at
Name DOB

_____
Street Address City State Zip Code Telephone Number

be accepted for psychiatric, mental health, medication management or alcohol and drug abuse treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic, evaluation, medication and treatment services from Silver Psychotherapy.

2. I have been given information regarding my rights and responsibilities as a participant.

3. I have been given information regarding the limits of confidentiality of my records.

4. I have been given information regarding the cost of services from Silver Psychotherapy.

5. I understand that I am responsible to pay a copay/payment, and that it is payable each time I come for treatment.

6. I understand that I may address any concerns or grievances with my therapist or any other representative of my insurance carrier at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.

7. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.

_____
Signature of Participant or Legal Consenter Date

_____
Witness Date

MINOR (Emancipated Minors Only):

Due to the following reason

_____,

Reason

I have the legal capacity under applicable _Maryland_____law to apply for consent to such treatment and services mentioned in this form, without parental consent.

_____

Signature of Participant Date

_____

Witness Date

PARENT OR GUARDIAN:

I, _____, do hereby state that I am the
Parent or Legal Guardian

natural parent or legal guardian of the participant; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____

Signature of Participant Date

_____

Witness