Informed Consent for Treatment (for all practitioners)

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by _____ (name of provider), a behavioral healthcare provider.

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral healthcare providers directly supervising the services received by the patient.

If the patient is under age 18 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.

- **I have been provided education on my primary diagnosis of** _____

Signature _____ Date _____

Relationship to Patient (if applicable):_____

Informed Consent for Medication (for use by medication prescribers only)

Name(s) of Medication: _____

_____ (provider prescribing medication) has educated me regarding the medication that has been prescribed to (please check one of the following) _____me, _____my child, or _____a person for whom I am the legal guardian, and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication if the person taking this medication becomes pregnant (including discussing with my doctor my desire to become pregnant or breastfeed before becoming pregnant). I have also been informed of the reason or purpose for which this medication was prescribed.

- **I have been provided education on my primary diagnosis of** _____

Patient Name: _____

Patient/Legal Guardian Signature: _____

Provider's Signature: _____

Date: _____