INFORMED CONSENT FOR TREATMENT

I agree and consent to participate in psychiatric services offered by a provider at North Carolina Neuropsychiatry, PA. I understand that I am consenting and agreeing to services provided within the scope of my provider's license, certification, and training or the scope of a provider's license, certification, and training who is directly supervised within the practice. I understand that I may see another provider within the practice, if my provider is unavailable.

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 or I am legally authorized to initiate and consent to treatment on behalf of this individual. I will provide a copy of my custody and/or guardianship papers as requested.

I understand that I, as a patient or legal guardian, have the right to consent or refuse treatment or habilitation at any time. My refusal of treatment or habilitation will not be used as grounds for discharge or potential discharge unless the advised treatment is the only option available at this practice.

Patient Name: _____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if applicable) Date

I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his/her provider for further clarification.

_____ _____
Witness Signature Date