

**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.

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