Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **CONSENT FOR CARE** |

I, the patient or patient’s legal representative, hereby grant permission to Family Psychiatric Care to perform such examinations and medical and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient’s diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine is not an exact science and that not guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: Date:

Patient Printed Name:

**The authorization below is given on the patient’s behalf because the patient is either a minor or unable to sign.**

Name: Relationship to Patient:

Signature: Date:

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| **ACKNOWLEDGEMENTS** |

I acknowledge that I have been offered the following documents:

-Notice of Office Policies and Procedures including instructions in case of emergency

-Notice of Privacy Policies

Patient Signature: Date:

Patient Printed Name:

**The authorization below is given on the patient’s behalf because the patient is either a minor or unable to sign.**

Name: Relationship to Patient:

Signature: Date: