Psychiatric Alternatives & Wellness Center

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Consent For Treatment

I consent to allow myself/my child to receive treatment under the care of a psychiatrist and/ or psychotherapist at Psychiatric Alternatives and Wellness Center (PAWC). Treatment includes but is not limited to psychotropic medication as well as individual, group, couples, or family therapy. I understand that all information between my doctor and me is kept confidential and that PAWC keeps records of my treatment. I acknowledge that I have been informed that Psychiatric Alternatives and Wellness Center's Notice of Privacy Practices is available on their website and that this document provides further information about the limits of this confidentiality and how my private health care information may be used and disclosed.

My signature below indicates that I have read, understand and will comply with the information contained within PAWC consent for treatment and policies. A copy of these forms is available upon request.

Patient Name: ____ Patient's DOB: _____________________

Patient Signature: ______________________________________ Date: _____________________________

Parent/ Guardian Name: ________________________________ Relationship to Patient: _______________

Parent/ Guardian Signature: ___________________________________ Date: _____________________

Parent/ Guardian Name: ________________________________ Relationship to Patient: _______________

Parent/ Guardian Signature: ___________________________________ Date: _____________________

Clinician's Signature: ____ Date: _____________________