

Consent for Treatment

Patient Name _____ **DOB** _____

By signing below, you are stating that you have read and understood policy statement as posted on my website (libusmd.com) and you have had your questions answered to your satisfaction.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of patient (please print) _____

Signature: _____ Date: _____

Psychiatrist/Witness: _____ Date: _____