TREATMENT CONSENT

I/we are providing consent for ______________________________________
Patient's name
to receive treatment for ____
Disorder being treated
with the following treatment(s):

____

____

____

I/we understand the following:

- That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including _______
  ____
  ____
- That I/we have had the opportunity to have all questions answered to my/our satisfaction.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

____ Date _____________
Patient signature*

____ Date _____________
Parent/legal guardian

____ Date _____________
Treatment provider

* If patient is a minor, signature may be required, depending on state law.

Mary C. Nowlin, DO, DLFAMA, DFAACAP, FACN

Child Adolescent and Adult Psychiatrist

7050 West Bell Road
Suite 12
Glendale AZ 85308

8414 East Shea Bvd.
Suite 102
Scottsdale AZ 85260

Phone: 623-322-7301

Fax: 623-337-9562

CONSENT FOR TREATMENT

As you know, I share an office with Counselors at the Glendale office and at the Doan Counseling in Scottsdale AZ. I am an independently practicing professional and share only office space with these two Counseling Centers. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent legal guardian or conservator) consents to, and authorizes services, by Mary C. Nowlin, DO. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. **Be informed of and participate in the selection of treatment modalities.**
2. **Receive a copy of this consent.**
3. **Withdraw this consent at any time.**

______________________________	______________________________
Signature of patient	Date signed
______________________________	______________________________
Signature of parent, Legal Guardian or Conservator	Date Signed