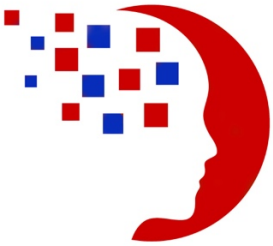

Wadsworth Psychiatric Services, PLLC

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 Name

_____ Date _____
Patient/Parent/legal guardian

_____ Date _____
Treatment provider