deborah *farber*, aprn

Informed Consent For Treatment

I, ______________________________ agree and consent to participate in psychiatric services provided by Deborah Farber APRN. I understand that I am consenting and agreeing only to those services that she is qualified to provide within the scope of her license and board certification.

If the patient is under 16 years of age, I have legal custody of this individual named ____________________, and am authorized to initiate and consent for treatment on behalf of this individual. See signature below as acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF POLICIES REGARDING CONFIDENTIALITY, INFORMED CONSENT STATEMENT AND PATIENT RIGHTS AND RESPONSIBILITIES STATEMENT

Signature:_______________________________________ Date:____________