DEBORAH FARBER, APRN

Lauren Wilson, PMHNP-BC
Beth Chadwick, PMHNP-BC

Informed Consent For Treatment

I, ______________________________________ agree and consent to participate in psychiatric services provided by Deborah Farber, APRN, Lauren Wilson, PMHNP-BC and Beth Chadwick, PMHNP-BC. I understand that I am consenting and agreeing only to those services that she is qualified to provide within the scope of their licenses 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: _______

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