

CROWNVIEW MEDICAL GROUP, INCORPORATED

CONSENT FOR TREATMENT

I hereby authorize and request **CROWNVIEW MEDICAL GROUP, INC** to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, CROWNVIEW MEDICAL GROUP, INC can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychotherapeutic process can initiate and bring up uncomfortable feelings of and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient/Guardian Signature _____ Date _____

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize **CROWNVIEW MEDICAL GROUP, INC** to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative _____

Relationship to Patient _____

CONFIDENTIAL