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**CONSENT FOR TREATMENT**

**General Consent:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize/consent a Dynamic Interventions, Inc. licensed therapist to provide evaluation, counseling, and supportive help for myself and/or my family.

It has been explained to me that we will take an active role in our youth’s treatment and will always know the benefits, risks, and/or side effects of all medications and treatment choices.

I have been provided , discussed and fully understand the Client Bill of Rights, Notice Privacy Practices and Limitations to Confidentiality, and written information about the Process for filing Grievances or Complaints. I further understand that I can contact Dynamic Interventions, Inc. at (478) 333-6197 should I have questions or concerns

**Consent for Treatment:**

I do hereby consent to mental health evaluation including but not limited to psychiatric evaluation, medications and any necessary medical examinations, laboratory services and other services which my child and/or family may require, and as may be ordered by the physician. I further consent to treatment by authorized employees or agents of Dynamic Interventions, Inc., who are assigned to my (their) care. I understand the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments, examinations or medical/psychiatric care. I acknowledge that I can ask questions about my care. **Please note: Prescriptions will not be called in if a patient has canceled or skipped an appointment. You must be seen in the office to receive a written prescription.**

**Follow-up Consent**

[ ] **I consent** to staff of Dynamic Interventions, Inc., contacting me within 90 days of the termination of this period of service, in order to collect information on the outcomes of that service. I further consent to such contact being made through the following persons nominated by me:

**Contact Person:** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] **I do not consent** to follow-up contact.

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Patient Name (please print) Parent/Guardian Name (please print)

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Parent/Guardian Signature Date

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Therapist Name/Credentials **(Please Print)** Date

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Therapist Name/Credentials (**Please Sign)** Date

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**Specific Consent(s)**

□ Yes □ No **Transportation of Child/Children** – I authorize a staff member of Dynamic Interventions, Inc. to transport my child/children as needed. During these times, the parent/guardian agrees to release Dynamic Interventions, Inc. from all liability and responsibility.

□ Yes □ No **Consent to Treatment & Involvement** – Following my evaluation, service options have been discussed with me and the probable outcome with or without intervention was discussed with me. I have had the proposed program of treatment fully explained to me. I give my permission for Dynamic Interventions, Inc. to provide counseling and other treatment services to me and significant others as indicated. I consent that our entire nuclear family (Parents/Caregivers, and children) participating fully, along with the following extended family members (Uncles, grandparents, etc.) and/or significant others (Neighbors, friends, church members, etc.) and/or agencies’ involved in my treatment, payment for services or Dynamic Interventions, Inc. healthcare operations as outlined in Dynamic Interventions, Inc. Notice of Privacy Practices.

**Family/Significant Others: (Obtain Authorizations)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Relationship **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Agencies/Service Providers: (Obtain Authorizations)**

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□ Yes □ No **Refusal to Treatment:** I have had the proposed treatment recommendation(s) explained to me. I voluntarily choose not to accept this offer of treatment, and refuse to enter the program(s) indicated below. If already involved in a treatment program, I rescind/reject this treatment program

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Patient Name (please print) Parent/Guardian Name (please print)

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Parent/Guardian Signature Date

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Therapist Name/Credentials **(Please Print)** Date

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Therapist Name/Credentials (**Please Sign)** Date