CENTER FOR EMOTIONAL HEALTH®

CONSENT TO TREAT

For Adults:

I, _____, consent to the following:
(Patient's Name)

- ❑ Outpatient Therapy
- ❑ Medication Management
- ❑ Drug Testing
- ❑ Medical care deemed necessary by CEH medical staff
- ❑ Emergency medical intervention on my behalf

X_____ X_____
Name of Patient (Print) Date

X_____ X_____
Signature of Patient Date

For Minors:

I, _____, (Parent/Guardian of _____,
(Parent/Guardian's Name) (Patient's Name)

DOB:____/____/_____), consent to the following:

- ❑ Outpatient Therapy
- ❑ Medication Management
- ❑ Drug Testing - We do NOT conduct drug testing on minors unless specifically required, and only with prior parental or legal guardian consent.
- ❑ Medical care deemed necessary by CEH medical staff
- ❑ Emergency medical intervention on my behalf

X_____ X_____
Name of Patient (Print) Date

X_____ X_____
Signature of Parent/Legal Guardian Date