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TREATMENT CONSENT FORM

Your signature here indicates that you have read the treatment consent form, which contains information on psychiatric services, sessions, professional fees, billing and payments, insurance reimbursements, cancellation and no-show policies, professional records, confidentiality, contacting me, and practice status, and you agree to abide by its terms during our professional relationship.

Name of patient (print):____ Date: ___________

Signature of patient: ____

Name of Psychiatrist (print): ____ Date: ___________

Signature of psychiatrist: ____