NICOLE HRANIOTIS, MD
Child, Adolescent & Adult Psychiatry

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Nicole Hraniotis, M.D. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands the following:

1. That I/we have the right to be informed of and participate in the selection of treatment modalities.
2. That I/we have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options, including all of the above treatments/therapies.
3. That I/we have had the opportunity to have all questions answered to my/our satisfaction.
4. That I/we have the right to receive a copy of this consent.
5. That I have the right to withdraw this consent at any time, and that this consent is given voluntarily.
6. That withdrawing consent for this treatment will not prejudice my continued treatment relationship.
7. I attest that if the patient is a minor or otherwise dependent on me, that I am the natural parent or legal guardian of that patient, and therefore, I am authorized to make this request for and to give my consent for the treatment.
8. That I am legally competent and have the authority to provide consent for treatment.

_____ _____

Patient Signature Date Signed

_____ _____

Signature of Parent, Legal Guardian or Conservator Date Signed

_____ _____

Signature of Witness (if appropriate) Date Signed