

**CONSENT FOR TREATMENT**

I voluntarily consent to any outpatient evaluation, treatment, and all education, training, and technical assistance deemed appropriate by my professional service provider that is in accordance with quality care and evidence-based practices performed by clinicians at the Dr. Deb’s Center for Child and Family Development. This consent for treatment is valid for all outpatient care that is provided for one (1) year from the date I sign this agreement. I understand that I can revoke this consent for treatment at any time in writing to Dr. Deb’s Center for Child & Family Development.

**CONSENT TO RECEIVE CALLS AND TEXT MESSAGES**

I consent to receive calls from Dr. Deb’s Center for Child & Family Development for my protected healthcare and other services at the phone numbers listed in my chart, including my cell phone number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

BY SIGNING BELOW, I AM AGREEING TO THE AUTHORIZATIONS, CONSENTS, AND RELEASES DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PATIENT’S SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S PRINTED NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF THE SIGNATURE ABOVE IS NOT THE PATIENT’S, INDICATE BELOW THE RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT.

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
(e.g., Parent, Guardian or Authorized Representative)