

FREEDOM COUNSELING CENTER, INC.

(269) 982-7200 FAX (269) 982-0202

INFORMED CONSENT FOR TREATMENT

Patient: _____ Date of Birth: _____ Age: _____

Sex: _____ Marital Status: Married Single Widowed

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Email: _____

Primary Phone _____ Mobile Home Work

Secondary Phone _____ Mobile Home Work

Employer/School: _____

Spouses Name: _____ Address (if different): _____

Emergency Contact: _____ Relationship: _____

Telephone: _____ Mobile Home Work

If Client is a Minor (under 18) – Parent, Guardian, or Responsible Party: _____

Address: _____ Phone: _____

SS#: _____ DOB: _____

Employer: _____ Phone: _____

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided at/by Freedom Counseling Center, Inc., a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above provider is qualified to provide within: (1) the scope of the provider's license, certification, & training; or (2) the scope of license, certification and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual & consent to treatment on behalf of this individual.

Patient Name (please print or type)

Patient's/Parent or Guardian Signature

Date