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