ADVANCED PSYCHIATRIC GROUP
APG RESEARCH, LLC.

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721 N MAGNOLIA AVE . ORLANDO FL . 32803
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TREATMENT CONSENT FORM

NAME: _____

SOCIAL SECURITY NUMBER: _____

DATE: _____

Explanation of Consent Form

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Advanced Psychiatric Group. This form documents that the patient has consented to treatment at Advanced Psychiatric Group, including but not limited to medicine management, psychotherapy and counseling. This allows the professional staff at Advanced Psychiatric Group to provide services to you.

This form provides evidence that no guarantee is made by any professional at Advanced Psychiatric Group concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at Advanced Psychiatric Group. If you have any questions concerning this or any other matters, it is your responsibility to ask your psychiatrist or therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment

I _____ , for _____do hereby voluntarily consent to care and
(PRINT YOUR NAME) (PRINT THE CLIENT'S NAME)

treatment by Advanced Psychiatric Group, assistants and/or designees. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the psychiatrist or therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending in treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

_____ _____
SIGNATURE DATE

_____ _____
WITNESS DATE