Informed Consent for Treatment

I, ________________________, agree and consent to participate in behavioral health care services provided by ______________________________. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and/or am authorized to initiate and consent for treatment on behalf of this individual.

Signature___________________________________ Date __________________

Relationship to Patient ____

Acknowledgement of Receipt of Privacy Notice

Please be sure you have read the Notice of Privacy Practices for Protected Health Information.

I Hereby acknowledge receipt of these privacy policies.

Signature:____

Date: ____

Contact Information

I, ____
Give permission for Knoxville Psychiatric Group to contact me at:

Phone Number(s):____

The Caller may leave messages: (check all that apply)

___On Answering Machine

___With: ____

___May speak to me only.

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