# CONSENT FOR EVALUATION AND TREATMENT

Revised 11/20/19

Patient Name:_________________________ DOB:_______________________

The undersigned patient or responsible party (parent or legal guardian) consents to, and authorizes services, by Dr. Ayanna Cooke-Chen. These services may include psychiatric evaluation, psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that ***the initial visit is only for evaluation purposes and does not guarantee entry into this practice.*** If care cannot be provided, then an attempt will be made to refer to an appropriate provider.

For minor children: In cases of divorce, separation, adoption, and other kinship or guardianship situations, the undersigned agrees to provide up-to-date information and court documents substantiating that the undersigned has the right to make medical decisions on behalf of the patient. The undersigned agrees to provide contact information for pertinent parents/guardians who are not present, so that Dr. Cooke-Chen can make good-faith efforts to ensure that all medical decision-makers are in agreement with the course of treatment.

The undersigned understands that he/she has the right to:

1. Be informed of diagnoses, to be informed of and participate in the selection of treatment modalities, and to ask questions to his/her satisfaction.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

_______________________________________ _________________

Signature of Patient Date

_______________________________________ _________________

Signature of Parent or Guardian Date