FARRAR & ASSOCIATES
MENTAL HEALTH

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CONSENT TO TREATMENT

I or my legal ward will be receiving psychotherapy, assessment and/or psychiatric services at Farrar and Associates Mental Health (FAMH). I have had the opportunity to review clinical policies and procedures. I have been informed of my client rights and authorize FAMH to provide mental health services. I understand I will be informed of the benefits of the proposed treatment, the way treatment will be administered, the approximate length of treatment and any potential negative effects of the treatment, including potential side effects from medications. I will receive information regarding alternative treatment methods and potential consequences of not receiving treatment, as well as after hours urgent coverage. I understand I may request additional clarification on any of these topics from my clinician.

This consent remains in effect throughout the duration of treatment or up to 12 months, and may be withdrawn by written request at any time. I am aware that my case may be periodically reviewed by consulting therapists, psychologists, psychiatrists and affiliated staff members.

By signing below, I acknowledge that I have been offered the following documents:

- A copy of Client Rights and the Grievance Procedure for Community Services.
- A copy of Farrar and Associates' policy for involuntary termination of Services.
- A copy of the Notice of Privacy Practices.
- A copy of my Patient Expectations form for services offered at FAMH.

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Print Patient/Legal Guardian Name	Patient/Legal Guardian Signature	Date