ClearPath Psychiatry & Counseling

Consent for Treatment

I hereby authorize ClearPath Psychiatry & Counseling to provide psychiatric evaluation, medication management, and/or psychotherapy services.

1. Voluntariness: I understand that my participation in treatment is voluntary, and I have the right to terminate treatment at any time.

2. Risks and Benefits: I understand that behavioral health treatment carries both risks and benefits. Treatment may involve discussing difficult topics, which can lead to uncomfortable feelings. However, it can also lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

3. Emergencies: I understand that ClearPath Psychiatry & Counseling is not an emergency crisis center. In the event of a life-threatening emergency or active suicidal/homicidal thoughts, I agree to call 911 or go to the nearest emergency room.

Patient/Guardian Signature: _____ Date: _____