Lake Area Psychiatry, LLC

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Lake Charles, LA 70601
Phone: 337.478.9331
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CONSENT FOR TREATMENT

By my signature below, I consent to receive treatment from _____, for
Provider Name

Mental health services for myself or my minor child.

I understand that treatment means the provision, coordination, or management of health care and related services, consultation between providers and staff of Lake Area Psychiatry relating to an individual, or referral of an individual to another provider for health care.

I understand that I may revoke this consent at any time by notifying, _____
Provider Name

or staff at Lake Area Psychiatry in writing.

This consent will expire on the following date: _____, or on the date that following event occurs:

___ Completion of treatment as agreed upon by you and _____.

OR

___ You revoke this Consent for Treatment in writing.

_____ _____
Name of Patient (Please Print) Patient's Date of Birth

_____ _____
Patient Signature Date

_____ _____
Name of Parent/Legal Guardian Parent/Legal Guardian Name (Print)

_____ _____
Witness (Please Print) Date Witnessed

_____
Signature of Witness