

CONSENT TO TREAT

Full Name: _____ Date of Birth:

I (or my represented patient) consent to receive in-person/telehealth mental services from Compassionate Behavioral Health Care, LLC, including evaluations as needed follow-ups. This form of care may include video conferencing, audio communication, and/or electronic transmission of medical information. I acknowledge that Compassionate Behavioral Health Care, LLC will bill my insurance. I can discontinue services at any time by providing verbal or written notice.

Patient or Responsible Party's Signature:

Patient or Responsible Party's Name: _____ Date of Consent:

Details of the Responsible Party giving Verbal Consent to treat and to receive communication through phone calls, SMS text, DocuSign, Email

Name: _____

Phone Number: _____ Email:

Date and Time when Verbal Consent was obtained:

Additional Notes:

Self-Pay: ☐ Yes ☐ No _____