SSQ PSYCHIATRY LLC

GENERAL CONSENT / PERMISSION FOR TREATMENT

Welcome to SSQ Psychiatry LLC (hereinafter "Company"). We are located at _____.

Please read this document carefully. Feel free to request discussion or ask questions of your physician before signing.

I, the undersigned, authorize the performance of such appropriately indicated examinations, testing, and other routine diagnostic procedures and treatments as my/the patient's physician consider to be necessary or appropriate for the purpose of diagnosis of my/the patient's condition. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand, and that I am free to refuse anyone or all procedures or treatments if I so choose.

I consent to the diagnostic testing and/or disposal by Company of any blood, urine or other body fluids, stool specimens or tissues which are obtained in accordance with routine Company practice and governmental regulation. I further consent to the examination, study and retention of such specimens, and the use of the findings for medical purposes.

I consent to the present and future prescription and/or administration of medicines or drugs by Company as may be deemed necessary by my/the patient's physician in the course of my/ the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.

I understand that the explanation which will be given to me of the nature, intended purpose, and the reasonable foreseeable risks, consequences, complications, benefits and alternatives of the examination(s), procedure(s) or treatment(s) which may be performed or used in the course of diagnosis or treating my/the patient's condition will not be exhaustive and that other risks and complications may arise but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent such explanation will be given to me.

I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury and even death.

I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make any inquiries regarding any aspect of my/the patient's diagnosis or treatment which I do not understand. I represent to my/the patient's physician that I am eligible to give this consent.

Signature of Patient _____

Date _____

Signature of Parent or Legal Guardian _____

Relationship to Patient _____

Date _____