Wellness Healthcare Clinics

Informed Consent to Mental Health Treatment Form

I consent to receive health treatment from Wellness HealthCare Clinics (WHC) to address mental health concerns and symptoms. I understand that additional information of side effects, benefits. I also understand other information concerning feasible treatment will be explained to me during the treatment process.

Printed Name of Consumer: ____

Consumer's Signature: ____________________________________ Date: __________________

THIS PORTION SHOULD BE COMPLETED BY A LEGAL GAURDIAN OR SUBSTITUTE CARE GIVER/DECISION-MAKER IF THE CONSUMER IS CERTIFIED AS INCAPACITATED.

I have the legal right to accept or refuse mental health treatment for:

Print Consumer's Name: ____

I consent to (*print consumer's name*) ___________________________________ receiving mental health treatment for purpose of addressing mental health issues.

Signature: ____________________________________ Date: _____________________________

Print Name: _______________________________________

Relationship to Consumer: _______________________________

4660 Martin Luther King Jr Ave SW,
Suite A1-A3, Washington, DC 20032
(202)318-0179
http://www.whcclinics.com