SP ASSOCIATES

Consent for Treatment

I am voluntarily seeking psychotherapy and/or psychiatric treatment by the psychiatrists, physican assistants, and/or psychotherapists at Statesboro Psychiatric Associates for the purpose of diagnosis and treatment, and I do hereby consent to such examinations, treatments and/or diagnostic procedures as may be deemed advisable by my treating physician, physician assistant or psychotherapist. I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science and I acknowledge that no guarantees have been made as to the result of such examinations, treatments and/or diagnostic procedures. I also understand that while the course of my treatment or treatment of my child is designed to be helpful, it may at times be difficult or uncomfortable.

Minor Patients: By signing below, you agree that you have legal custody and authority to consent to the child's treatment. You further agree that if you share custody of the child, all parties who have legal custody of the child have been made aware of, and consent to treatment at Statesboro Psychiatric Associates.

Consent for Telepsychiatry/Psychotherapy Services: I understand that if I am scheduled for telehealth services that the software platform utilized by SPA to facilitate video sessions meets HIPAA privacy requirements, and I accept this treatment modality.

By signing below you state that you have read and agree to this **Consent for Treatment** in its entirety.

_____ _____

Print Patient's Name Patient's Date of Birth

_____ _____

Signature of Patient *Digital Signature Date

_____ _____

Signature of Parent/Guardian/Personal Representative Date
*Digital Signature

If not signed by the patient, please indicate:

Relationship:

○ parent or guardian of minor patient

○ health care surrogate or conservator of an incompetent adult or emancipated minor patient.