320 W. Lanier Ave., Suite 200, Fayetteville, GA 30214 • Tel 404.566.5402

Informed Consent for Treatment

Patient's Name ______________________________

I, ___________________________________ (name of patient), agree and consent to participate in behavioral health care services offered and provided by Dr. Tiffanie Davis Henry (name of provider), a behavioral provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of license, certification, and training of the behavioral health care providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature:______________________ Date:________________

Relationship to Patient (if applicable):_______________________