



SHERBONDY'S

PSYCHIATRIC SOLUTIONS

225 Adley Way – Greenville, SC 29607

General Consent for Care and Treatment Consent

This consent provides us with your permission to perform reasonable and necessary medical examinations and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician the purpose, potential risks and benefits of any test ordered for you, if you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, or Physician's Assistant), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Relationship to Patient

Witness Initials

Office Staff
Witness