Child and Adolescent Psychiatric Solutions

6500 Brooktree Rd. Suite 208. Wexford, PA. 15090 Phone (724) 799-8558 Fax (412) 430-3383

Informed Consent to Treatment

Patient Name: _____ D.O.B.:_____

I, _____ or my child_____, have/has voluntarily participated in an evaluation at Child and Adolescent Psychiatric Solutions. The diagnosis and the extent of any specific problems have been adequately explained to me. Also, I have been informed of the risks and benefits of any proposed treatment, the risks and benefits of alternative treatments, and the likely effect of no treatment.

I have read the above information and understand what treatment services will be provided. Any questions I have about the above matters have been answered by Child and Adolescent Psychiatric Solutions staff.

I voluntarily consent to receive the recommended treatment.

_____ _____

Patient (14 years and older) Date

_____ _____

Parent or Legal Guardian (if patient is a minor) Date