SENDAN CENTER
excellence in child & adolescent mental and behavioral health

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All patients 13 years of age or older must sign to consent for their own treatment.

Consent for Treatment

By my signature below I consent to receiving mental and behavioral health (and related services, as appropriate, e.g. speech language or learning services) assessment, evaluation and/or treatment at Sendan Center.

Patient's printed legal name (first and last) Patient's Date of Birth (MM/DD/YYYY)

Patient's preferred or prior name (if applicable)

Patient Signature Date signed Time

Receipt of Sendan HIPAA Notice of Privacy Practices

The Sendan Center HIPAA Notice of Privacy Practices describes in detail your rights and our responsibilities regarding how your health information may be used and disclosed, and how you can access your information. It is available on our website and in hard copy at our office.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient's printed legal name (first and last) Patient's Date of Birth (MM/DD/YYYY)

Patient's preferred or prior name (if applicable)

Patient Signature Date signed Time

This form will be retained in the patient's medical record.