



Acknowledgement for the Receipt of Patient Documents

INFORMED CONSENT TO TREATMENT

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Informed Consent for Treatment document.

_____ CLIENT (14 years and older)	_____ DATE
_____ PARENT AND/OR GUARDIAN (for clients under 14 and/or for parents with shared legal custody of a minor)	_____ RELATIONSHIP TO CLIENT
_____ 2 nd PARENT (needed for parents with shared legal custody of a minor)	_____ RELATIONSHIP TO CLIENT

Note: A parent or parents must sign for children under 14 years old. If you are 14 years or older, you have the right to consent to voluntary treatment on your own.

In shared legal custody situations, consent from both parents to treat a minor child is required. Your therapist will review requirements for parental consent in other custody situations with you

NOTICE OF PRIVACY PRACTICES

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Notice of Privacy Practices document.

_____ CLIENT (14 years and older)	_____ DATE
_____ PARENT AND/OR GUARDIAN (for clients under 14)	_____ RELATIONSHIP TO CLIENT

STATEMENT OF RIGHTS AND RESPONSIBILITIES

Your signature below indicates that you have read the information, understand it, agree to abide by its terms during your professional relationship with GOC and that you have received the Statement of Rights and Responsibilities document.

_____ CLIENT (14 years and older)	_____ DATE
_____ PARENT AND/OR GUARDIAN (for clients under 14)	_____ RELATIONSHIP TO CLIENT
_____ WITNESS (GOC therapist)	_____ DATE

This form will be retained in your medical records