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Psychiatrist – Patient Contract
Outpatient Services

Acknowledgment and Consent

Your signature below indicates that you have received a copy of our Psychiatrist-Patient Contract, that you have read the information in this document, that you understand the information, and that you agree to abide by its terms for the duration of our professional relationship.

Signature: _____

Relationship to patient:
Same ☐ Parent ☐ Guardian ☐ If other please specify: _____

Name Printed: _____

Name of patient: _____
If same as above, check here: ☐

Today's Date: _____

Original to file
Copy to patient