# Kolossal Healthcare

***INFORMED CONSENT FOR TREATMENT***

I hereby request that I,_____
(Name)
born,_____ be accepted for mental health and/or alcohol and drug
(Date of Birth)
to the following statements.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Kolossal Healthcare Services LLC.
2. I have been given information regarding my rights and responsibilities as a patient.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services. I understand that I may be responsible to pay a co pay and that it is payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my therapist at any time. I understand that may also contact the licensing board which regulates my therapist's professional practice.
6. I am freely choosing to enter treatment, and I understand that I may discontinue at any time.
7. I have been given information about the Risks and benefits of the treatment recommended as well as other alternatives.

_____ _____
Signature of Patient or Parent/Guardian Date

---

Parent or Guardian:

I, _____ do hereby state that I am the natural parent or legal guardian of the patient: therefore. i am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

_____ _____
Signature Date