Client Name: _____ Client Date of Birth: _____

Informed Consent for Treatment
Catalpa Health, Inc.

I, _____ agree and understand the treatment plan for my child,
(Print Name Parent or Guardian)

_____, and authorize Catalpa to provide outpatient mental health services.
(Print Name of Client)

IF CLIENT IS AGED 14 OR OLDER, PLEASE COMPLETE THIS SECTION

I, _____, acknowledge that I have participated in the development of my treatment
(Print Name of Client)
plan, agree with it, and authorize Catalpa to provide outpatient mental health services.

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1. I have been provided specific, complete and accurate information about the treatment and have had time to study the information and/or seek additional information concerning the treatment, including: (a) desired and possible outcomes and possible risks of the treatment(s) (including side effects); (b) treatment recommendations and benefits; (c) the way the treatment is to be administered and services are to be provided; (d) approximate duration of treatment; (e) alternative treatment modes I may pursue; (f) probable consequences of not receiving this treatment; and (g) the approximate fees that the client or another responsible party will be expected to pay for the proposed treatment.

2. I understand that I have the right to withdraw this Informed Consent for Treatment at any time, in writing.

3. I understand that this Informed Consent for Treatment is in effect for fifteen (15) months from the date signed, at which time Catalpa may ask me to sign a new Informed Consent for Treatment, or until the time that I may elect to withdraw this Informed Consent for Treatment.

4. I have been advised that I may have a copy of this Informed Consent for Treatment, if I so request.

5. I acknowledge that I have been informed my or my child's case will become inactive after discontinuation of treatment, but this will not prevent me or my child from returning for services in the future.

6. I acknowledge that I have been informed of the following rights:
   a. Client Rights and Responsibilities, and the Grievance Procedure.
   b. How to access emergency services.
   c. Confidentiality of client information.
   d. Who to contact to get information about the cost of treatment.
   e. The right to request to meet with Catalpa's clinical manager.
   f. Appointment Cancellation Policy.
   g. Catalpa's Discharge Policy, which includes circumstances under which a client may be involuntarily discharged.

7. The undersigned certifies that he/she has read the foregoing and is competent to execute it, or is authorized to execute if on another's behalf.

8. This Informed Consent for Treatment is good for fifteen (15) months from the date signed.

_____ _____
Signature of Client (if aged 14 or older) Date

_____ _____
Signature of Parent/Legal Guardian Date

**You may request a photocopy of this document