



GENERAL CONSENT

I consent to evaluation and treatment of the condition for which I, my child or dependent, have come to **Seven Hills Psychiatry and Behavioral Health Services**, and authorize the physicians and other health care providers affiliated with **Seven Hills Psychiatry and Behavioral Health Services**, to provide such evaluation and treatment. I understand that health care providers in training may be involved in my care and treatment and consent to their involvement. I understand that the practice of medicine is not an exact science, and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis, or test performed at or by **Seven Hills Psychiatry and Behavioral Health Services**. I acknowledge and agree that this consent will be applicable to all visits or episodes of evaluation and treatment at **Seven Hills Psychiatry and Behavioral Health Services**. I have had an opportunity to discuss it, and any questions I have had have been answered to my complete satisfaction.

Signature of Patient, Parent, or Legal Guardian

Date
