COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-4000
f. (443) 546-4005

www.collaborativecounselingcenter.com

Consent for Care

I, the patient or patient's legal representative, hereby grant permission to Collaborative Counseling Center to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine and mental health services are not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: _____ **Date:** _____

Patient Printed Name: _____

If the authorization above is given on the patient's behalf because the patient is either a minor or unable to sign, please specify who signed below:

Printed Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____