Informed Consent

I consent to care from Community of Hope for myself or the patient named below. I understand that this care may include behavioral health / emotional wellness services, dental or medical treatment, special tests, evaluations, or procedures that may be done, requested, or directed by my provider.

I understand the nature and purpose of COH's services, other possible methods of treatment, and possible risks involved.

I understand that no guarantees have been given to me as to the outcome of any examination or treatment.

I understand that I may change my consent at any time.

I have read (or have read to me), and understand the information in this document. I have had all my questions answered fully.

Name of Patient (Printed): _____

Signature of Patient: _____ Date:_____

If needed:
Name of Patient Representative (Printed):_____

Relationship to Patient: _____

Signature of Patient Representative: _____ Date:_____