FAULKNER UNIVERSITY
CENTER FOR THERAPY AND RESEARCH

Consent to Treat

I,_____(legal guardian or self), as a parent or guardian of _____(minor patient), or for myself as an adult patient, consent to receive any services considered necessary and appropriate by the clinical team at Faulkner University's Center for Therapy and Research.

I understand that:

This is a pro-bono teaching clinic. Services will be provided by students and/or an attending licensed provider.

I meet the eligibility requirements to attend the clinic.

Services may be observed by undergraduate students, graduate students, faculty, staff, or others.

All provided services will be recorded via audio and videotape. These recordings may be used for educational, security, and research purposes.

Medical Information will be shared between my medical provider and the clinic.

Patient data may be used in research studies, and any information used will be anonymized.

Failure to abide by the attendance policy will result in discharge of services.

I have the right to withdraw from or refuse treatment or services at any time. If I choose to exercise this right, I may be removed from the patient list. Once removed, I may request to be re-added subject to any waitlist policies.

I have the right to discuss all evaluation and treatment options with the attending provider and/or student clinician.

_____ _____

Signature of Patient/Legal Guardian/Power of Attorney Date