



Elizabeth O. Dania

NP in Psychiatry, PLLC

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Psychiatric Mental Health Services
191-15 115TH Avenue, Saint Albans, NY 11412
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Consent to Treatment

I acknowledge that I have received information regarding psychiatric treatment, medication management, and/or psychotherapy services. I understand the nature and purpose of treatment and have had the opportunity to ask questions regarding my care.

I understand that no guarantees or promises have been made regarding treatment outcomes. I understand that I may discontinue treatment at any time, although I remain financially responsible for services already rendered.

I understand the office cancellation policy and agree to provide at least 72 hours notice for appointment cancellations when possible.

I authorize the release of information necessary for insurance processing, payment, and coordination of care.

Client Signature: _____ Date: _____

Printed Name: _____

Provider Signature: _____ Date: _____