3500 N. Causeway Blvd. Ste. 1410
Metairie, LA 70002
Phone: (504) 838-9919
Fax: (504) 834-3101

Informed Consent

I understand that by seeking treatment from _____,
I recognize that I have a condition requiring treatment and authorize him or her to provide it.

I will adhere to the treatment plans that we agree upon. I realize that there is no guarantee for the outcome of any treatment.

I understand that patients being treated with medicine classified by the Drug Enforcement Administration as scheduled (controlled) drugs may be asked at random to produce a specimen for analysis.

There are limits to confidentiality regarding mandatory reporting and safety. These should be discussed with your provider.

In case of emergency, I authorize the above named professional to contact the following people. An emergency is a situation in which there is an immediate and serious threat to safety.

NAME	PHONE NO.	ADDRESS	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(PRINT) PATIENT'S NAME:_____

PATIENT/GUARANTOR'S SIGNATURE:_____

DATE: _____