RUTTENBERG AUTISM CENTER

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CONSENT TO TREAT

Patient Information	
Patient's Name:	**Patient DOB:**
Patient SSN:	**Date:**

Statement of Consent:
I have reviewed my rights and treatment plan with my patient advocate or Qualified Professional and having been provided due consideration, I give my consent and authorization for treatment, training, and assistance programs, and all other medically needed services. I understand that I have the right to refuse any treatment services, and that I will not be discriminated against on the basis of race, national origin, sex, age, religion, or disability. With my signature, I am verifying that I have been informed of the benefits and risks, as well as alternative treatment modes, and the consequences of not receiving treatment.
Acknowledgement of Consent:
I understand that I may revoke my consent in writing at any time. This consent is valid for one year from the date below.

Patient/Guardian/Authorized responsible adult signature: **Relationship to Patient:**	**Date:**
Signature of Patient (14 years of age or older)	**Date:**
Ruttenberg Autism Center Employee Signature:	**Date:**

If not revoked sooner, this consent automatically expires upon _____ or one year from the date that it is signed.