The Joy of Life Clinic
Revive. Thrive. Live Fully

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Provider: Mercy Nwankama, CRNP-PMH

Effective May 1, 2024

Treatment Consent Form-Adult

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above.

I acknowledge that I have had input into the development of the treatment plan.

I agree to the treatment recommendations discussed with the provider and agree to comply with the treatment expectations.

I have actively participated in the development of the treatment plan and understand the goals and objectives listed within the plan.

I have had an opportunity to address any questions or concerns with the provider. All questions or concerns have been adequately addressed.

By signing below, I agree with the treatment plan discussed with the provider and have been offered/received a copy of the treatment plan.

Name:		
Signature:		Date:
Provider:		
Provider's Signature:		Date: