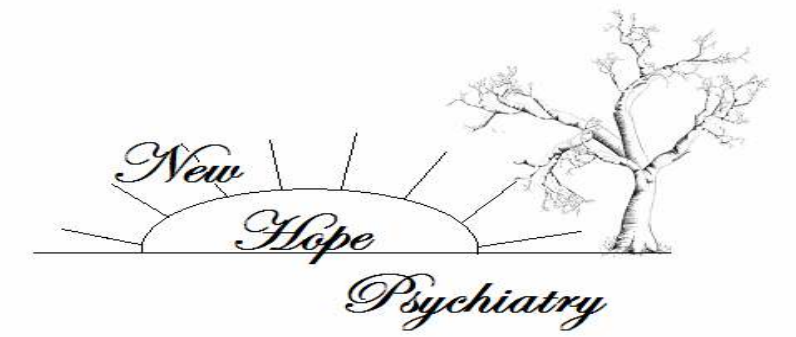
New Hope Psychiatry, PLLC



Wayne Chang M.D.
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Fredericksburg, VA 22408
Phone: (540) 357-7101 Fax: (540) 361-1874

PATIENT NAME**:**_____ (please print)

I, _____, do voluntarily consent to psychiatric treatment provided by Wayne Chang M.D. for myself or the patient listed above for whom I am the legal guardian and have the legal authorization to consent for treatment for this individual.

I understand that I am consenting and agreeing only to the services that the above named provider is qualified to provide within the scope of the above named provider's license, certification, and training.

I understand that psychiatry is not an exact science and no guarantees are being made as to the results of assessment and/or treatment.

I understand that I am an active participant in this treatment and that I share the responsibility for the treatment process, including goal setting and termination.

I understand that assessment and/or treatment will be kept confidential with the exception of legal limitations of confidentiality. I have been provided with the opportunity to read the HIPAA Notice of Privacy Practices and all of my questions have been answered.

I understand that I have the right to revoke this consent in writing and terminate services with the above named practitioner at any time.

I have read and understand the information on this sheet. My signature indicates my informed consent with the above named practitioner.

_____ _____ _____
Signature Relationship to patient Date