Mankato Mental Health Associates
Union Square Building
201 N. Broad Street, Suite 308
Mankato, MN 56001

Consent for Treatment

I affirm that I have read and understand the policy statements detailed in the document *Mankato Mental Health Associates, P.A., Informed Consent for Mental Health Treatment* (revised 3-4-22), and am hereby requesting and consenting to mental health treatment including counseling and/or psychiatric medication management services.

I,_____hereby request mental health services from Mankato Mental Health Associates, P.A. and understand and agree to all practices as described in the aforementioned document. I understand that receipt of these services is fully voluntary and that I may withdraw this consent and terminate services at any time, for any reason.

CLIENT SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE_____

Guardian Consent for Treatment

I hereby authorize Mankato Mental Health Associates, P.A. to provide

_____counseling/psychotherapy

_____psychiatric medication management, including consent for neuroleptic medications if deemed necessary and appropriate by the provider

services for _____, for whom I am the parent or guardian. In my role as parent/guardian I agree to participate as an active member of the treatment team and will make myself available for consultation with the mental health provider as requested to ensure that treatment interventions are implemented in a timely fashion to ensure optimal treatment outcomes.

PARENT or GUARDIAN SIGNATURE _____ DATE_____

WITNESS SIGNATURE _____ DATE_____