## Serenity and Sage Counseling, LLC

Client Name:	Client	Date of Birth:	
	ID/MRN:		

## **Advance Directive**

I am at least 16 years old and I have been informed about the Advance Directive document and choose:

**TO COMPLETE an Advance Directive with my Mental Health Provider** 

□ NOT TO COMPLETE an Advance Directive with my Mental Health Provider.

Client Signature	Date	
Parent/Legal Representative Signature	Date	
	Date	

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