Halton Hills
Family Health Team

INFORMED CONSENT TO ASSESSMENT & TREATMENT

I (we) have reviewed HHFHT's *Client Information Form* and understand the policies relating to FHT mental health services, including the cancellation policy, and the limits to confidentiality. My (our) signature(s) below indicate that I (we) accept their policies and our agreed treatment plan.

I (we) understand the meaning of "*informed consent*" and agree to request clarification if I (we) ever have any questions about the assessment and/or treatment process, its goals, procedures, possible risks, and anticipated outcomes.

I (we) understand that I am (we are) free to stop the assessment and/or treatment for any reason at any time.

Print Patient Name	Signature of Client/Guardian	Date
Print Name	Signature of Client/Guardian	Date
Print Name	Signature of Client/Guardian	Date

Witness	Date
Emergency Contact (Relationship)	Phone

Ontario