


PSYCHIATRIC  
CONSULTANTS  
OF FLORIDA, LLC

*SPECIALIZING IN ADULT, CHILD AND ADOLESCENT,  
FORENSIC PSYCHIATRY AND ADDICTION MEDICINE*



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(954) 272-7848 FAX

## INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I voluntarily consent to the rendering of diagnostic procedures and/or psychotherapeutic treatment by Daniel I. Bober, D.O., LLC., and/or professional staff who are under his/her supervision and direction that are necessary for my care. I understand that I may withdraw my consent for specific service or treatment at any time to the extent permitted by law. I understand that this withdraw must be submitted in writing.

If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment or I am legally authorized to initiate and consent to treatment on behalf of this individual. I will provide a copy and/or guardianship papers as requested.

I hereby certify that the foregoing information is accurate and complete and that I will notify the office of any changes in a timely manner. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I may have made in completion of this form.

\_\_\_\_\_  
Patient Name/Guardian Signature

\_\_\_\_\_  
Date

BOARD CERTIFIED BY THE  
AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY  
DIPLOMATE OF THE  
AMERICAN BOARD OF ADDICTION MEDICINE