



Sovereign Health of California (SHoCA)
209 Avenida Fabricante, Suite #100, San Clemente, California 92672
Tel. 949.369.1300 Fax 949.498.2619

CONSENT FOR TREATMENT

I, _____
Authorize and request that Sovereign Health of California provide psychological/neuropsychological services which are advisable now or during the course of my care or my child's care as a client. Services provided include psychotherapy, therapeutic assessment, psychological assessment, neuropsychological assessment, cognitive remediation, and patient education.

I understand that Sovereign Health of California will verbally explain to me the purpose and procedures of specific services to be rendered.

I understand that Sovereign Health of California is a sole proprietor and is not legally affiliated with other professional in the office suite.

I have read and fully understand the Consent for Treatment Form.

SIGNATURE

(Signature of patient or patient's Legal Representative)

Date: _____

Printed Name

(If signed by someone other than the patient, state your relationship to the patient)