BRUCE ELIASHOF, MD
Psychiatry
Psychotherapy & Clinical Hypnosis

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INFORMED CONSENT

INFORMED CONSENT TO TREATMENT

I hereby make application for myself to receive care and treatment voluntarily from Bruce Eliashof, M.D.

I understand that such care and treatment may consist of an evaluation process, psychotherapy, or hypnosis with or without medication. I authorize Bruce Eliashof, M.D. to administer this treatment to me.

This consent does not waive my civil rights. I reserve the right to decline treatment or withdraw from treatment at any time. I also understand that I have the right to an explanation of the treatment to be administered.

I understand that Bruce Eliashof, M.D. is not affiliated with any hospital at the present time. If admission to a hospital is required for my care, it will need to take place through my own primary care physician or insurance plan or the emergency room.

I have read and understand all of the above information.

Patient signature _____

Printed name _____

Date _____