RIVER OAK CENTER FOR CHILDREN
5445 Laurel Hills Drive
Sacramento, California 95841

CONSENT TO TREAT

I consent to the behavioral health services provided by River Oak Center for Children for

____.

Parent/Legal Guardian Signature ______________________________________ Date: __________

Parent/Legal Guardian Signature ______________________________________ Date: __________

Signature of Minor of 12 years or older __________________________________ Date: __________

Signature of Adult receiving services __________________________________ Date: ___________

Staff Signature ____ Date: ___________

Client Name: __________________________________ DOB _______________ Program ________________

Form Revised 1/1/14