TMS GREENWICH
TRANSCRANIAL MAGENTIC STIMULATION

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Cos Cob, CT 06807
203.769.1365
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TMSGreenwich.com

Consent For Treatment

___ I/We declare that I am/we are the sole legal guardians for the patient listed below:

___ I/We also grant TMS Greenwich my/our medical permission and informed consent for the mental health evaluation & treatment for

PATIENT NAME (print):_____Date: _____

Patient Signature (13 & over): _____Date:_____

Parent/Guardian name (print): _____Date:_____

Parent/Guardian Signature: _____Date:_____

Provider Signature: _____Date:_____