

CONSENT FOR TREATMENT

- I hereby consent to receive behavioral health services as provided by _____, and have been informed of her professional and legal credentials to perform as a counselor.

- I authorize and request the administration of assessments and treatments considered advisable in the diagnosis and treatment of my condition. I understand that counseling is a collaborative process utilizing our emotional, thought and behavioral processes to achieve our desire goals for treatment. I understand my therapist uses traditional and approved counseling techniques that will respect my values, beliefs, faith and relationships and will do no intended harm.

- I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment. My therapist has informed me of the benefits and risks of therapy and I am entering therapy with full knowledge that my anxiety , depression and discomfort my increase before any relief is experienced.

- I hereby release _____, from responsibility for any injury or harm which results from my terminating services against clinical advice.

- I have been given a Policy and Procedure form that explains fees, payments, confidentiality, insurance and appointments. I have signed this form and received a copy for my files.

- I understand the agreed upon fee per session is and that this fee is due in full at the beginning of each session, unless another arrangement has been made.

- I agree that I will provide 24-hour notice to cancel a scheduled appointment. If I do not give proper notification, I understand I am responsible for the full session fee. I understand that failed appointments will not be shown on receipts for services.

- I have the right to withdraw my consent to treatment by informing my therapist in writing and attending a final counseling session.

This form has been fully explained to me and I certify that I understand and agree with its contents.

Client Name(s): (Please Print) _____

Client Signature: _____ Date: _____

Parent/Guardian Signature(s): _____ Date: _____

Therapist Signature: _____

Client did not sign because: _____