

CONSENT TO TREATMENT

Name of Patient: _____

Date: _____

Date of Birth: _____

Name of Therapist: _____

I, _____,
(hereinafter "Patient") acknowledge that I have received and/or will be receiving the "Information for Clients" document and other pertinent information about the therapy I am considering, and have had an opportunity to discuss my options, have all questions answered and make an informed decision on how to proceed forward.

I understand that developing a treatment plan with the therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in the process of developing my individual treatment plan and an active role in our sessions. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand that while psychotherapy may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings or may lead to the recall of troubling memories.

I understand that I may stop my treatment with the therapist at any time. Further:

PERSONAL: I understand that the therapist is not liable nor can I attempt to hold the therapist liable for any issues or problems that may arise due to my independent decision to terminate my treatment and understand that I may lose out on other services if I stop said treatment.

COURT ISSUED: I understand that the therapist is not liable nor can I attempt to hold the therapist liable for any issues or legal problems that may arise due to my independent decision to terminate my treatment and understand that there may be additional legal ramifications for violating a Court Order.

I understand that if I no show or cancel an appointment with less than 24 hours notice, this will count against my total number of sessions and I will be charged for the appointment. before the time of the appointment.

I understand I shall only be responsible for paying for services and treatment sessions already rendered; however, I understand that if payment for the services rendered has not been received nor made in a timely manner, the therapist has the unilateral right to stop my treatment.

I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by the Therapist.

Patient's signature: _____ Date: _____

Printed Name: _____

IF TO PATIENT UNDER THE AGE OF 18 AT THE TIME OF AUTHORIZATION

Minor's Parent/Guardian: _____ Date: _____

Printed Name: _____

Relationship to Patient: _____

I, the Therapist, have discussed the Consent above with the Patient or his/her parent, guardian, or other representative (if applicable). My observations of the Patient's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Patient's signature: _____ Date: _____

Printed Name: _____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.