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### Consent to Treatment

I acknowledge that I have received and have read (or have had read to me) the introductory forms provided to me about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the provider named in the letterhead above. I understand that developing a treatment plan with this provider and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided.

I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

\_\_\_\_\_  
Signature of Client or Guardian/Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Guardian/Representative Relationship to Client

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

\_\_\_\_\_  
Signature of Provider

\_\_\_\_\_  
Date

Copy accepted by client    Copy kept by provider

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