**Consent to Treatment**

I acknowledge that I have received and understand the information about the therapy I am considering (such as my rights, confidentiality policy, risks and benefits, and cancelation policy.) I have had all my questions answered fully. If at any time during the treatment I have questions about any of the subjects discussed I can talk with my therapist about them and have them answered. I also understand that it is my right and responsibility to choose the therapist and type of therapy that I feel best suits my needs.

I understand that after therapy begins I have the right to withdraw my consent to therapy at any time, for any reason. However, I will make every effort to discuss my concerns about my progress with my therapist before ending therapy. When I choose to stop treatment with this therapist the only thing I will still be responsible for is paying for the services I have already received.

I understand that no specific promises have been made to me by this therapist about the results of treatment, the effectiveness of the procedures used by this therapist, or the number of sessions necessary for therapy to be effective. I understand that developing a treatment plan with this therapist 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.

My signature below shows that I understand and agree with all of these statements I do hereby seek and consent to take part in the treatment by the therapist named below.

Signature of client (or person acting for client): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client (if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the therapist, 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 therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

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