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# Consent to Treatment

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I acknowledge that I have received, have read and understand the information about the therapy I am considering, for myself or minor child. I have had all my questions answered fully.

I do herby seek and consent to take part in the treatment by the therapist named above. 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 and/or the best interest of the minor child. 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 procedure provided by the therapist.

I am aware that I may stop treatment with this therapist 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 is court ordered, I will have to answer to the court).

I know that I must call to cancel an appointment at least 48 hours ( 2 days) 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), and providers of any services or treatments that I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

As the parent of the minor child, I understand the above stated policies and consent to the treatment of the minor child. _____ Initial of parent:_____

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

_____ _____

Signature of client ( or person acting for the client, parent of minor child) Date

_____ _____

Printed Name Relationship to client