PSYCHOLOGICAL & COUNSELING SERVICES, PC

INFORMED CONSENT FOR TREATMENT

TODAY'S DATE:_____

CLIENT NAME:_____ DATE OF BIRTH:_____

SOCIAL SECURITY NUMBER:_____

(Note: If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.)

I give consent for evaluation and treatment to be provided for myself/my child by (name of therapist) _____.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
    1. The therapist believes that I am in danger of hurting myself or someone else, and
    2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I will have ongoing opportunity to ask questions about the treatment process.

_____ _____

Signature of Client or Parent/Guardian Date

_____ _____

Printed Name Relationship to Client

_____ _____

Witness Signature Date

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