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CONSENT FOR TREATMENT

I, _____, hereby give my consent to

_____to provide mental health services to me; or I,_____,

(Parent/Guardian) to the above named patient, hereby give my consent for treatment.

I understand that: **(please initial)**

_____While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and or mental health treatment; I realize that particular results cannot be guaranteed.

_____Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make to make life changes.

_____The clinician is not providing any emergency services. After hours, holidays or weekends I am to contact 911 or go to the nearest emergency room in the event of a mental health emergency.

_____Regular attendance will assist in maximum benefits. I have been advised that I am free to discontinue treatment at any time. If I decide to discontinue treatment I will notify the clinician at least two weeks in advance so that effective planning or continued care can be implemented.

_____Conversations with the clinician will remain confidential; with the exception of reporting actual or suspected child or elder abuse/neglect to appropriate authorities, and to protect any one I may threaten with violence, harmful or dangerous actions (including self-endangerment). The clinician is required by law, and has the legal responsibility to report unlawful actions if they cannot be resolved.

I know of no reason why I should not or cannot undertake this counseling and/or mental health treatment and agree to participate fully and voluntarily.

Signature of Patient or Legal Representative:_____Date: _____

(If signed by other than patient, state relationship & authority to do so)

Witness_____ Date:_____