Orlando Counseling Services

Consent to Treatment

This form is to document that I, _____, give my permission and
PRINT NAME

consent to the above named clinician to provide psychotherapeutic treatment to me and/or

_____, who is/are my child/children or for whom I am
PRINT NAME(S)

legal guardian, custodian, or legal Power of Attorney.

I understand the following:

- Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
- Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
- This therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend and evening hours.
- Regular attendance will produce maximum benefits, but I am free to discontinue treatment at any time.
- Conversations with the therapist will be almost always confidential. However, the therapist, by law, must report actual or suspected child, spouse, or elder abuse to the appropriate authorities. The therapist also has a legal responsibility to protect anyone I may threaten with violence, harmful, or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. The therapist will make reasonable efforts to resolve these situations before breaking confidentiality.
- I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

I have read and received the *Office Policies & General Information Agreement for Psychotherapy Services* and I agree to the policies. I have discussed any concerns about the policies with the therapist **prior** to signing this consent.

Signature:_____ Date: _____