CONSENT TO TREATMENT

1) I _____ authorize and request Elizabeth Venart, Licensed Professional Counselor, to carry out psychological and/or diagnostic procedures and interventions which now or during the course of my treatment are advisable. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting my treatment goals are in my best interest. I agree to play an active role in this process. No promises have been made to me as to the results of treatment or of any procedures provided, however, the therapist may discuss the probable course of my therapy and realistic expectations of a particular outcome.
2) I am aware that I may stop my treatment with this therapist at any time, and shall only be responsible for payment of any outstanding fees. I understand that the therapist would prefer I discuss with her my reasons for leaving, to permit her to address my concerns, obtain closure, and possibly refer me to another professional.
3) I know that I must contact the therapist to cancel an appointment at least 48 hours before the time of the scheduled session. If I do not cancel in time or fail to show up, I will be charged for that appointment as detailed in the *Financial Agreement* which I have read and agreed to.
4) I am aware that, if I am requesting receipts for my insurance or EAP organization, an agent of my insurance company or other third-party payer may be given information about treatment, including but not limited to, the type(s), cost(s), and date(s) of any services or treatments I receive. I understand that if a payment for the services I receive here is not made, the therapist will be forced to stop my treatment.
5) I acknowledge that I am being informed that under Pennsylvania law:
   a) If I communicate to my therapist a serious threat to harm an identifiable person, the therapist must warn that person and the police.
   b) If the therapist suspects child abuse or neglect, or abuse of a helpless adult or of an elder, a report must be made to the designated agency.
   c) If I appear to be a danger to myself or others, or am unable to care for myself, then hospitalization may be required.
   d) Information and records--otherwise confidential-- concerning me and or my family must be provided in the event of a court order.

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

_____

CLIENT SIGNATURE / DATE

_____

CLIENT SIGNATURE / DATE (if relevant – for couples counseling)

_____

PARENT SIGNATURE / DATE (if relevant – for children under 18)

My observations of this individual's behavior and responses thus far give me no reason to believe that she/he is not fully competent to give informed and willing consent. I will provide my services to this person with a full and ethical commitment to meeting their needs in accordance with my profession's best standards of practice.

_____

THERAPIST SIGNATURE / DATE

Has client received a copy of this form? [ ] YES [ ] NO _____