Tammy Powell, PCC, LLC

CONSENT FOR TREATMENT

Client Name: _____ DOB: _____

I understand that my treatment will include a mental health assessment, treatment sessions if recommended by the assessing therapist, and a treatment plan if I choose to engage in treatment. I understand that the treatment plan that will be developed for me should I engage in treatment will be based on the therapist's best recommendations for addressing the problems I present. I understand that engaging in treatment may result in unforeseen outcomes, such as changes in my relationships with family members or friends. I understand that obtaining the desired results of treatment depends on factors such as the effort I make toward changing, the consistency with which I keep appointments and follow treatment recommendations, or changes in my family and other life circumstances. I understand that I am free to seek this or any other treatment elsewhere, and that part of the recommended treatment may include a referral to another provider.

My signature on this document indicates my consent to be assessed and interviewed, and this consent applies to me and/or my children.

_____

Signature of Client Date

_____

Signature of Parent, Guardian, or Personal Representative Date

_____

(*If you are signing as a personal representative of an individual, please describe your legal authority to act on behalf of this individual (e.g., power of attorney, healthcare surrogate, etc.).)

_____ Initial for client refusal of acknowledgement or agreement of receipt

_____

Signature of Provider Date