



CONSENT TO TREATMENT

I, _____ DOB: _____, do hereby seek and consent to participate in treatment by Dr. Carol L. Clark, PA I understand the nature of the treatment to which I am consenting and have been informed of the potential advantages and disadvantages of that treatment. I have had an opportunity to ask all my questions and have received satisfactory answers to all of my questions.

1. I have been given and fully understand information regarding my rights and responsibilities as Dr. Clark’s client.
2. I have been given and fully understand information regarding the limits of confidentiality of my records.
3. I have been given and understand information regarding the cost of services from Dr. Clark. I understand and agree that I am responsible for all fees and co-payments, payable each time I come to treatment. I am aware that I may terminate my treatment at any time without consequence, but that I will still be responsible for payment for the services I had received. I am aware that if I have not paid for services received, my treatment may be discontinued by Dr. Clark.
4. I am aware that the development and review of my progress, or of a Treatment Plan, is in my best interest and may be required by governmental, funding, accrediting or other agencies and I agree to actively participate in this process.
5. I am aware that the practice of psychotherapy or counseling is not an exact science and so predictions of the effects are not precise or guaranteed. I acknowledge that no guarantees have been made to me regarding the results of treatment or procedures provided by Dr. Clark
6. I understand that I may address any concerns or grievances with my therapist or any other representative of my insurance provider at any time. I understand that I may also contact the licensing board which regulates DR. Clark’s professional practice.
7. I am aware that any cancellations of appointments must be made more than 24 hours in advance of the appointment and if I do not cancel or do not show up I will be charged for that appointment.
8. I am aware that this office or therapist is not responsible for any personal property or valuables I bring into its facilities. I acknowledge that if I, or anyone else for whom I am legally responsible, deliberately causes damage or steals any property of this office, I will be held financially responsible for its replacement.

I certify, with my signature below, that I have read, had explained to me where necessary, fully understand, and agree with the contents of this Consent to Treatment.

Signature of Client or Parent/Legal guardian

Date

Signature of Witness

Date