**Consent to Treatment**

I acknowledge that I have received, have read (or have had read to me), and understand the "Professional Disclosure Statement" and/or other information about the therapy I am considering. I have had all my questions answered fully. I do hereby seek and consent to take part in the treatment by Alicia McArthur, LCMHC. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged a fee for that appointment. I understand that this fee is not reimbursable by insurance.

I am aware that my therapist is only in-network with certain insurance companies at this time, and that I am responsible for paying any co-pays or co-insurance at the time of service if in-network. If my therapist does not participate in network with my insurance company, I understand that I am responsible for paying the full fee at the time of service and for filing any claims for reimbursement directly with my insurance company. I understand that, at my written request, the therapist may disclose information about my treatment to my insurance company to assist in the processing of my claims. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

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

_____ _____

*Signature of client (or person acting for client)* *Date*

_____

*Printed name /Relationship to client (if necessary)*

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

*Signature of therapist* *Date*

❑ Copy accepted by client ❑ Copy kept by therapist

*This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.*