INFORMED CONSENT FOR TREATMENT

I hereby request that _____
DOB: _____
Address:_____

be accepted for mental health treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Noah E Enteen, LMFT
2. I have been given information regarding the limits of confidentiality of my records.
3. I have been given information regarding the cost of services. I understand that I am responsible to pay that cost or a co-pay and that it is payable each time I come for treatment, unless other arrangements were agreed upon. I understand that my credit card will be charged following the counseling session if payment wasn't collected during the session or, if I missed the scheduled session and didn't cancel or reschedule the appointment within 24 hours or more prior to the scheduled counseling session.
4. I understand that I may address my concerns or grievances with my therapist or my insurance company at any time. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
5. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
6. I have been given information about the advantages and disadvantages of the treatment.

_____
(Signature of client or Legal Guardian)

_____
(Witness)