INFORMATION AND CONSENT TO TREATMENT

The signature below indicates that I have read and understand the terms and conditions of this informed consent statement in its entirety and I consent to treatment as has been outlined in the packet I received. I authorize the release of my clinical record information, as necessary, to my insurance company for the purpose of healthcare credentialing, payment reimbursement, utilization review and quality assurance review.

Client _____ Date: _____

Parent/Legal guardian _____ Date:_____
(if required)

This page to remain with therapist records.