Yvette Brindle-Decancq, LMHC, CBC
Licensed Mental Health Counselor
Certified Behavioral Consultant

Consent to Treatment

I, _____, acknowledge that I have had all my questions about treatment answered fully and to my satisfaction.

I seek and consent to take part in treatment with the therapist named below. 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 understand and agree to play an active role in the therapy processes.

I understand that no promises have been made to me about 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. If I do, I will have to pay for the services I have already received. I understand that I may lose other benefits 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 within 48 hours prior to the time of scheduled appointment. If I do not cancel or do not show up, I will be charged per stated in Financial Agreement signed.

I am aware that my health insurance company or other third-party payer may be given information about my diagnose(s) and life functioning, as well as the type(s), cost(s), date(s), and providers of any services or treatments I receive. 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 legal representative Printed name Date

_____ _____

Printed name of legal representative Relationship to client

I, Yvette Brindle-Decancq, LMHC, CBC, have discussed the issues above with the client. 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.

____/____/____ _____

Date Signature of Therapist

__ Copy accepted by client __ Copy kept by therapist

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

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