**INFORMED CONSENT FOR ASSESSMENT AND TREATMENT**

Name: Date of Birth:

I have been informed of my rights and responsibilities as a client. I have been informed of the credentials and qualifications of the provider providing my mental health assessment and treatment. I also understand that I have the right to ask questions about issues relevant to my therapy, such as the therapist’s values, background and attitudes, and to be provided with thoughtful respectful answers.

I understand that I have the right to be involved in the treatment planning process, including an explanation of the diagnosis, goal setting and evaluation of progress.

I understand that I have the right to ask questions regarding my treatment, including treatment strategies and interventions and can refuse to participate in the use of treatment strategies or interventions.

I understand that I may terminate therapy at any time and/or request a referral to another therapist or agency at any time during treatment.

I give consent for mental health treatment by Deborah Perrin, LMHP.

Signature of Client/Guardian Date

Therapist Signature Date

PAYMENT AUTHORIZATION

I authorize all medical benefits to be paid to Deborah Perrin, LMHP. I further authorize my counselor to release any medical information necessary to process all claims.

Signature of Client/Guardian Date