Consent for Treatment
HOLISTIC CARE FOR WOMEN (HCFW)

I have chosen to receive mental health services in the form of Behavioral/Psychotherapy counseling for myself and/or my child from Holistic Care for Women & Family. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Non participation and/or late cancellations may be grounds for termination of services. I understand that HCFW will not hold any responsibility for the safety or care of the client if the client discontinues treatment prematurely.

Supervision

I understand there are certain circumstances which may require HCFW provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision.

Client Rights

- The right to be treated with dignity and respect by all staff
- The right to be involved in the planning and/or revision of my treatment plan
- The right to know about my treatment progress or lack thereof
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
- The right to be spoken to in a language that is fully understood
- The right to a clean and safe environment
- The right to refuse to be videotaped, audio recorded, or photographed
- The right to end treatment at any time unless court ordered
- The right to file a complaint or grievance about the agency or staff
- The right to confidentiality of clinical records and personal information according to federal and state laws

I have read, discussed and understood all of the above.

_____
Signature / Date

_____
Witness / Date