Croton Children and Family Counseling

Consent For Treatment

I, _____, hereby authorize Croton Children and Family Counseling to provide therapy services to myself/my child, _____. I understand and agree to the following terms:

Treatment Authorization:

I give my consent for Croton Children and Family Counseling to conduct therapy sessions with myself/my child for the purpose of addressing emotional, behavioral, and/or relational concerns. Therapy sessions may include individual, couple, family, or group sessions, depending on the nature of the concerns and treatment goals.

Therapist-Client Relationship:

I acknowledge that the therapist-client relationship will be confidential and based on trust, respect, and collaboration. The therapist will provide a safe and supportive environment for myself/my child to explore and address concerns.

Goals of Treatment:

I have discussed my/my child's treatment goals with the therapist and understand the objectives of therapy. I agree to actively participate in the therapeutic process and work towards achieving these goals.

Informed Consent:

I have received information about the nature of therapy services, including the therapist's qualifications, treatment approach, and potential risks and

benefits of therapy. I understand that I have the right to ask questions about the treatment and can withdraw consent at any time.

Confidentiality:

I acknowledge that the therapist will maintain the confidentiality of therapy sessions and will not disclose information without consent, except as required by law or when there is a risk of harm. There are certain situations where confidentiality may be breached, including instances of suspected child abuse or neglect, imminent risk of harm, or court-ordered disclosure.

Emergency Situations:

In the event of a mental health emergency or crisis situation, I authorize the therapist to take appropriate action to ensure safety and well-being, which may include contacting emergency services or involving other healthcare providers.

Fees and Payment:

I understand that therapy services are provided on a fee-for-service basis, and I am responsible for payment of session fees as outlined in the therapy practice's financial policies.

Duration and Termination of Treatment:

I acknowledge that therapy is a collaborative process, and the duration of treatment will depend on progress and ongoing needs. I have the right to terminate therapy at any time, and the therapist will discuss the process for ending treatment.

Other Treatment Options:

I understand that I have the right to explore alternative treatment options or seek therapy services from other providers if I believe it is in my best interest to do so.

By signing below, I acknowledge that I have read and understand the information provided in this Consent to Treat Form. I voluntarily consent to myself/my child to receive therapy services from at Croton Children and Family Counseling.

Client's Signature: Date:

Parent/Guardian Signature (if applicable): Date: