**Julie McCune LCSW**

**2207 Freeport RD**

**Natrona Heights PA 15065**

**724-224-3031**

***Consent to Treatment***

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the goals are in my best interest. I agree to play an active role in this process.

I understand that no promises are made regarding the results of treatment or of any procedures provided by this therapist.

I am aware I may stop treatment at any time. The only thing I will still be responsible for is paying for services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, fi treatment is court ordered, I may have to answer to the court.)

I am aware that an agent of my insurance company may be given information about the type, cost, dates and provider of any service or treatment 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 I understand and agree with all of these statements.

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Signature of Client Date

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Printed Name Relationship to Client

I the therapist, have discussed the issues above with the client. My observation 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.

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Signature of Therapist Date

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