Chime Mental Health Services
PO Box 121
Wells, MN 56097

Consent for Treatment Signature Page

I affirm I have read and understand the policy statements detailed in the document Chime Mental Health Services Informed Consent Information (revised 07.10.2021) and am hereby requesting and consenting to mental health treatment including counseling.

I hereby authorize Chime Mental Health Services to provide counseling/psychotherapy services for ____, for whom I am the parent/guardian. In my role as parent/guardian, I agree to participate as an active member of the treatment team and will make myself available for consultation with the provider as requested to ensure that treatment interventions are implemented in a timely fashion to ensure optimal treatment outcomes.

Client Signature (if appropriate): ____

Parent/Guardian Signature: ____

Witness Signature: ____