20231 Paint Boulevard
Shippenville, PA 16254
(814) 226-1159
Fax (814) 227-2876

850 Leonard Street
Clearfield, PA 16830
(814) 205-4004
Fax (814) 205-4013

ADULT CONSENT TO TREATMENT

I acknowledge that I have received, have read and understand the Client's Rights and Responsibilities and Statement of Patient Grievance Procedure. I have had all my questions fully answered.

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 treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedure provided by this therapist.

I am aware that I may stop treatment with this therapist at any time. The only thing I will still be responsible for is paying for the 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, if my treatment has been court ordered I will have to answer to the court.) I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment. I am aware that an agent of my insurance company or other third-party payer may be given information about the types, costs, dates, and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop treatment. I understand that I am responsible for any amount not covered by insurance. I understand that the Program may change their fee schedule at any given time.

My signature below shows that I understand and agree with all of these statements.

_____

Client's Printed Name

_____ _____

Client's Signature Date

I the therapist have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations 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.

_____ _____

Therapist's Signature Credentials Date

Client Name: Client ID: