**Consent for Treatment**

I, (print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do knowingly enter into agreement with and authorize Susan Potts Kimberly, LCSW to provide me counseling and psychological services. These services may include psychological assessment, counseling, and individual psychotherapy and/or referrals to outside services such as group therapy or psychiatry.

I understand that I have the right to decide not to enter therapy, not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue.

I understand that I have the right to complete and accurate information about my treatment plan, goals, methods, potential risks and benefits, and progress. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status.

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_

Therapist Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_