Treatment Informed Consent

Date:_____

Name:_____ **Date of Birth:**_____

Address:_____
_____

City, State, Zip:_____

Purpose of treatment/symptoms you are experiencing (depression, anxiety, etc.):

_____

General procedures used in treatment: Cognitive-behavioral and experimental methods.

Procedure's benefits, limitations, and risks: Benefits include improved functioning in social, vocational, educational, and/or relational areas. Limitations are those of any therapy, including the skills of the therapist and the capabilities and potential of the client. Risks include disturbance of emotional and functional aspects of your life.

Confidentiality (see Confidentiality Policy)

Therapist professional Involvement (see Letter of Agreement)

Method to obtain records information (see Letter of Agreement)

Treatment decisions (see Letter of Agreement)

Fees and Policies (see Letter of Agreement)

I hereby acknowledge that I understand and accept this informed consent for treatment.

_____

Signature **Date**

_____

Kari Moennig, LPC-MH, PLLC **Date**