



Beech Tree

Consulting &
Psychological Services

Consent to Treatment (Adult)

I do hereby seek and consent to take part in the treatment provide by _____, a mental health professional as defined by Indiana law. Treatment may include individual psychotherapy, group psychotherapy, psychological testing, couples therapy, and/or family therapy or a combination of several of these. I understand that developing a treatment plan with this clinician and determining the most appropriate combination of services is critical for effective treatment. I agree to work collaboratively with this clinician to review our work and progress toward meeting treatment goals.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this clinician.

I am aware that I may stop my treatment with this clinician at any time. If I choose to stop treatment, I will still be responsible for paying for the services I have already received.

I understand that I am consenting to only those mental health services that the above named clinician is qualified to provide within the scope of their professional license, certifications and/or training or within the scope of the license certification and training of those mental health professionals directly supervising the care you are receiving.

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

Signature of client (or person acting for client)

Date

Printed name

Relationship to client

I, _____, 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 reason to believe that this person is fully competent to give informed and willing consent.

Signature of Mental Health Professional

Date

_____ Copy accepted by client _____ Copy kept by therapist

6249 South East Street, Suite 1
Indianapolis, Indiana 46227

317 780 5750 phone
317 780 5755 fax

beechtreepsych.com

