

CONSENT FOR TREATMENT

I, _____, authorize and request that Ann Behringer, LCSW, provide psychotherapeutic assessment and treatment which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I agree to the 24 hour notice of cancellation policy and that there is a charge for sessions canceled in less than 24 hours.

I understand the limits of confidentiality regarding my treatment. Those limits have been described to me as: if I am a danger to myself or others, in child or adult abuse cases and/or if there is a subpoena for records by a court of law.

I have read and fully understand this Consent for Treatment form.

Patient Signature _____ Date _____