**Consent for Treatment**

**Carrie Mitchell Counseling, PLLC**

I consent for myself (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to participate in evaluation and ongoing psychotherapy treatment with Carrie Mitchell, MSW, LCSW, LCAS - Licensed Clinical Social Worker, Licensed Clinical Addictions Specialist. I am aware that the practice of psychotherapy is not an exact science and results cannot be guaranteed. No promises have been made to me about the results of treatment. I understand that I may withdraw from treatment at any time.

I have read and understood this policy statement, and I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement.

Signature of client or guardian/parent if client is a minor:

Name of the client (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_