the Center
for Christian Counseling, Consultation and Training, Inc.

INFORMED CONSENT FOR TREATMENT

Please Read and Sign Below

Your comprehensive assessment was completed and it has been determined that you are appropriate to receive mental health and/or alcohol/drug outpatient services from our clinic. The clinic wants you to be aware of your rights as a client and requests your informed consent to treat you. Your signature below indicates that you have been explained, understand and you are in agreement with the following:

1. I have been explained the treatment alternatives. (35.18(1)(b)) (75.03(11)(12))
2. I have been explained the possible treatment outcomes and side effects. (35.18(1)(c)) (75.03(11)(12))
3. I have been explained the treatment recommendations. (35.18(1)(d)) (75.03(11)(12))
4. The services, goals and duration of treatment will next be explained in my individualized treatment plan and reviewed regularly. (35.18(1)(e&g)) (75.03(11)(12))
5. I have been given the clinic's Client Bill of Rights.(35.18(1)(f)) (75.03(11)(12))
6. I have been given the clinic's Client Fee Agreement form which provides fee schedule, insurance, and payment explanation. (35.18(1)(h)) (75.03(11)(12))
7. I have been given the clinic's grievance procedure. (35.18(1)(i)) (75.03(11)(12))
8. I have been given the clinic's phone number and explanation on how to receive emergency services when the clinic is closed. (35.18(1)(j)) (75.03(11)(12))
9. I understand I could be involuntarily discharged by the clinic for violating clinic policy. (35.18)(1)(k)) (75.03(11)(12))
10. I understand if I am prescribed medication, I will need to sign a separate informed consent and explanation for each medication prescribed. (35.18(3)) (75.03(11)(12))
11. I understand that I can withdraw this consent in writing at any time. (94.03(f))
12. I understand that this form will be reviewed annually and I can request a copy of my patient's rights, explanation, grievance procedure, or discharge policy at any time. (94.03(g))

Your treatment is a cooperative effort between you and your therapist. Please feel free to discuss any alternative treatment methods as well as possible consequences of stopping or not receiving treatment with your therapist.

This consent for treatment will remain in effect until treatment is terminated, but not longer than twelve (12) months. You have the right to withdraw your consent for treatment at any time in writing. Please feel free to ask your therapist if you have any specific questions and we look forward to working with you and you can request a copy of any policy at any time.

Client Signature	Date
Client/Guardian Signature	Date
Therapist Signature	Date

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Just as you trusted Christ to save you, trust Him, too, for each day's problems. Live in vital union with Him. Colossians 2:6,7 (LB)