Cleveland Integrative Counseling
Consent to Treat

I hereby indicate that I have read, understand, and agree to all of the terms of the Cleveland Integrative Counseling available in print or online at www.clevelandint.com I hereby give my consent for the Clinical Staff of Cleveland Integrative Counseling to render counseling services and care to the minor child named below, including the performance of diagnostic and therapeutic procedures deemed advisable and discussed with me.

I am aware that participation in services is voluntary and I may limit or end services at any time. I understand I will be kept informed of the reasons for the treatment/ procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved.

I understand that I will be fully responsible for any and all charges at the current rates established by Cleveland Integrative Counseling for all services rendered to the individual named below. In the event that the balance due has to be collected by an outside agency or attorney, I agree to pay collection costs and attorney fees. This authorization may be revoked in writing at any time except to the extent those actions have been taken in reliance thereon.

I agree that all agreements and contracts between me and Cleveland Integrative Counseling are in writing and that there are no oral agreements between myself and Cleveland Integrative Counseling. Any modifications of the terms of this agreement must be in writing and signed by myself and my counselor.

This Consent for Treatment is a contract for services. I have carefully read and understand this contract. I agree that this is a legally binding contract. I agree that the provisions of this contract are reasonable, fair, equitable, and candid. I agree to this contract without undue influence, duress, or coercion from any source. I knowingly, willingly and without exception give my full informed consent to, and agree to abide by and be bound by, each and every one of the provisions contained herein.

Your signature below indicates that you have read and understand the Cleveland Integrative Counseling Policies and Procedures and consent to treatment for your minor child.

Date:_____

Name of Patient:_____

Name of Parent/Guardian:_____

Parent/Guardian Signature:_____

Patient Signature (if appropriate): _____

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