David Saavedra, LCSW
4800 North 10th St. Suite D
McAllen, TX 78504

CONSENT TO TREATMENT

This form is to document that I, _____, give my permission and consent to the above named clinician to provide psychotherapeutic treatment to me and/or _____, who is/are my spouse/child/children/_____.

While I expect benefits from this treatment, I fully understand that because of factors beyond our control, such benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I/he/she/we may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.

I understand that this therapist is not providing an emergency service, and I have been informed whom to call upon in an emergency during weekend and evening hours.

I understand that regular attendance will produce the maximum benefits but that I or we am/are free to discontinue treatment at any time. If I decide to do so, I will notify the therapist at least two weeks in advance so that effective planning for continued care can be implemented.

I understand that conversations with the therapist will almost always be confidential. I further understand that the therapist, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the therapist has a legal responsibility to protect anyone I/he/she/we may threaten, harmful or dangerous actions (including those to myself), and may break the confidentiality of our communications if such a situation arises. I understand that the therapist will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for treatment and for the fees.

I know of no reasons I/he/she/we would not undertake this therapy and I/he/she/we agree to participate fully and voluntarily.

Signature:_____ Date:_____
(of patient or person authorized to consent for patient)