St. Louis CENTER FOR Family Development LLC

Client ID# _____

CONSENT TO TREATMENT

If client is able to give consent for own treatment:

I, _____, consent to any and all services deemed necessary by St. Louis Center for Family Development, LLC, for my psychiatric evaluation, assessment, and counseling.

If client is a minor or has a legal guardian:

I, _____, am the (circle one: Parent / Legal Guardian) of _____. I consent to any and all services deemed necessary by St. Louis Center for Family Development, LLC, for the psychiatric evaluation, assessment, and counseling for my child/ward.

I give consent to care and treatment that falls within the scope of therapy practice as defined by the State of Missouri. I acknowledge that no guarantee has been made as a result of evaluation and/or treatment. I understand that I have the right to refuse any or all services, and that refusal of services may have a negative impact on the ability of St. Louis Center for Family Development, LLC to adequately assess and provide treatment.

Acknowledgements

_____ (initial) I acknowledge that I have read and do understand the Privacy Practices (HIPPA) of St. Louis Center for Family Development, LLC. I have received a copy of the Privacy Practices for my own records.

_____ (initial) I acknowledge that I have read and do understand the Office Policies of St. Louis Center for Family Development, LLC with regard to scheduling, referral, cancellations, and payment. I have received a copy of the Office Policies for my own records.

_____ (initial) I acknowledge that I have read and do understand the Consent to Treatment form of St. Louis Center for Family Development, LLC

_____ (initial) I acknowledge that I have read and do understand the Records and Information/Grievance and Appeal Procedure

Signature of client: _____ Date: _____

Signature of legal guardian or parent for client under age of 18:

_____ Date: _____