INFORMED CONSENT TO MENTAL/BEHAVIORAL HEALTH TREATMENT

PLEASE READ CAREFULLY BEFORE SINGNING THIS FORM.

I hereby give consent for mental health/behavioral health treatment and supports from:

___Althea Simpson, LCSW, LICSW/Brighter Day Therapeutic Solutions, PLLC

(Name of Provider)

for the purpose of addressing mental health/behavioral health concerns/symptoms. I understand that additional information about the probable consequences of not receiving treatment, side effects and potential risks and benefits, as well as information about feasible alternative treatments, will be further explained to me during the therapeutic treatment process.

1. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment for myself/my child at any time by providing a written request to the treating clinician.

2. **Expiration of Consent:** This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

Printed Name of Client: ____

____ ___________

Client's Signature Date

If the client is a minor or unable to sign, the authorized person must complete the section below.

I have the right to accept or refuse mental health/behavioral health services and supports for:

____

Print Client's Name

And I hereby affirm that I have legal authority to consent for him/her to receive treatment services and supports for the purpose of addressing mental health/behavioral health concerns/symptoms.

____ ___________

Signature of Parent/ Guardian (Person Legally Responsible & Authorized) Date

____

Printed Name of Parent/ Guardian (Person Legally Responsible & Authorized)

____

Relationship to client (Parent/Legal Guardian/Agency Representative)

For Agency Representative:

_____ (Initials) I have the authority to consent to mental health/behavioral health treatment for the above named child/adolescent.

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