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Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged a \$30.00 cancellation fee that must be paid before my next appointment can be scheduled.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment. Every effort will be made to assist you in processing insurance claims; however all charges incurred are the responsibility of the patient regardless of the insurance coverage or reimbursement. Outstanding balances should be resolved promptly. The therapist reserves the right to place an account for collection or pursue other collection methods.

My signature below shows that I understand and agree with all of these statements.

| | |
|--|---|
| _____ Signature of client (or person acting for client) | _____ Date |
| _____ Printed name | _____ Relationship to client (if necessary) |

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.



| | |
|---------------------------------|---------------|
| _____ Signature of therapist | _____ Date |
|---------------------------------|---------------|

- Copy accepted by client
- Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.