bowden & associates psychological and counseling services llc

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Treatment Consent

Patient Name: _____ DOB: _____

I hereby agree (or give permission for a child or other person for whom I am legally responsible) to receive services from ***Bowden & Associates, Psychological and Counseling Services LLC.*** I have received a copy of their *Statement of Policy, Confidentiality, and Fees* and agree to the stated terms.

I agree to provide information related to my problems and to participate in the development and implementation of my treatment plan.

I am aware that psychological and counseling services may provide benefit of improved relationship, improved ability to cope with problems of living, development of skills in areas such as communication, assertiveness, and growth in the areas of personal or spiritual goals and values. I am aware that in order to resolve difficult personal situations or life issues, treatment may involve the discussion of unpleasant experiences and exploration of painful emotions that can result in increased emotional stress.

While I expect benefits from this treatment, I understand that because of factors beyond my therapist's control (or other factors), such benefits and outcomes cannot be guaranteed.

I understand that ***Bowden & Associates*** reserves the right to collect any unpaid balance due. If I fail to make regular monthly payments on the account balance, a collection agency may be used, which may take legal action to secure payment, as authorized by state or federal law. Such legal action will become part of my credit record. I will be notified in writing before such legal action is instituted.

Signature: _____ Date: _____

Relationship to Patient: _____