Miriam Lieberman, MA, LCMHCS, HTCP
Integral Counseling Services, PLLC
miriam.lieberman@integralcounselingservices.com

CONSENT TO TREATMENT

This form is to document that I, _____, give my permission to Miriam Lieberman, MA, LCMHCS, HTCP 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 guarantees on personal growth and healing are impossible to issue due to factors beyond our control. I can expect to have an open dialogue with my therapist about my/or _____well-being and progress.

I understand that because of the counseling or therapy, I/he/she/we/may experience emotional strains, feel worse at times during treatment, and make life changes which could be distressing to myself or others. I understand that decisions I make regarding marital or job status, family relations, and the course of my life are solely my responsibility.

I understand that this therapist is not providing an emergency service, and I have been informed of whom to call in an emergency or during weekend or evening hours. If an emergency occurs (medical or psychiatric) while in the office I grant permission for my therapist to seek emergency medical care.

I understand that regular attendance will produce the maximum benefits but that I am/or we/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 planning for my continued care and closure can be worked out.

I understand that conversations with my 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 break the confidentiality if I/he/she/we pose a threat to myself or another/others.

I understand that I am financially responsible for the treatment fees and that I can withdraw my consent at any time and that refusal of my consent cannot be used as the sole grounds for termination of my treatment. I know of no reasons I/he/she/we should not undertake psychotherapy and I/he/she/we agree to participate fully and voluntarily.

Client rights and grievance policies have been reviewed with me and I have received a written summary.
☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES has been reviewed with me and I have received a written summary.
☐ Yes ☐ No

I have reviewed and agree to comply with all program policies and procedures.
☐ Yes ☐ No ☐ N/A

I have received information regarding my rights under Title VI of the Civil Rights Act of 1964.
☐ Yes ☐ No

Client: _____ Date: _____

Therapist: _____ Date: _____