CONSENT FOR TREATMENT

I hereby conset to receive behavioral health services through Lake Cook Behavioral Health as provided by psychologists, social workers, and counselors.

I authorize and request that Lake Cook Behavioral Health perform an assessment and administer treatment as may be advisable in the diagnosis and treatment of my condition.

I realize that no particular outcoome or results can be guaranteed as a results of my consent for treatment at Lake Cook Behavioral Health.

I hereby release Lake Cook Behavioral Health and their employees from responsibility for any injury which results from my leaving the Practice against clinical or medical advice.

Your treatment is confidential within the limits of the law. In general, no information about your treatment will be released without your written consent. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself or others, if your therapist learns of child abuse or neglect, or in some cases, ordered by a court.

If you (client) are younger than 12 years of age, your therapist may discuss your treatment with your parents or legal guardian. If you are older than 12 years of age and younger then 18 years of age, your therapist my discuss your treatment with your parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes places you in danger of significantly harming yoursel or others, your therapist will help you discuss these issues with your parents

This consent has been fully explained to me and I certify that I understand and agree with its contents.

Client Name:

Client Signature: Date:

If under 18, Authorized Parent or Guardian Signature:

Date:

Submit Cancel