



Rita Bryce, JD, LISW
Child, Adolescent, and Adult Therapist

Consent for Treatment

Name of Patient _____ Date of Birth _____

I am providing consent for _____
(Patient's name)

To receive treatment for _____
(Condition being treated)

With the following treatment(s): Psychotherapy, Cognitive Behavioral Therapy

I understand the following:

- I have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I have the right to withdraw my consent for this treatment at any time.

Patient Name (Please Print)

Date

Patient signature

Date

Parent/Legal Guardian (Please print)

Date

Parent/Legal Guardian signature

Date

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