New Jersey Counseling Training & Consultation Group-LLC

NJCTC-LLC: 280 Bloomfield Ave Verona NJ 07044
Telephone Contact Info: 201-259-7229; 201-951-3155; 973-800-2817 Fax: 973-857-0080
www.NJCTCGROUPLLC.org

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

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 or email to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged in full for that appointment.

I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

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. Re-disclosure or transfer is expressly prohibited by law.

Partners:
Joel Levine LCSW, LPC, LCADC, LMFT, SAP, NCC, ICADC, ACSW
Rob Johnson LPC, LCADC, NCC, ICADC