

# CONFIDENTIAL

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Affiliated Psychological & Medical Consultants, L.L.C.

## Treatment Consent Form

### Explanation of Consent Form:

This treatment consent form covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Affiliated Psychological & Medical Consultants, L.L.C. (hereafter known as APMC). This form documents that the client has consented to treatment at APMC, including but not limited to psychotherapy and counseling. This allows the professional staff at APMC to provide services to you.

This form provides evidence that no guarantee is made by any professional at APMC concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the staff at APMC. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

### Consent to Treatment:

I, \_\_\_\_\_, for \_\_\_\_\_  
(Print your name) (Print the client's name)

do hereby voluntarily consent to care and treatment by David S. Bailey, Ed.D., Stephen P. Farr, Ph.D., Janice R. Hughes, Ph.D., Caleb Loring, Psy. D., and Patricia McCoy, Ph.D., their assistants and/or designees. I am aware that the practice of Clinical Psychology and Neuropsychology is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the counseling process and that I share responsibility for treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

\_\_\_\_\_  
(Sign your name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date)