CONSENT TO TREAT

Client Name_____ DOB:_____

Address: _____

Phone:_____

I consent to diagnostic evaluations and clinical treatment to be provided for myself, my child, and my family by

Mindy Haber LCSWR, CASAC
11 Marshall Rd. Suite 2L
Wappingers Falls, NY 12590

Treatment may include individual therapy, family therapy, group therapy, and parent guidance. I understand and agree that as part of treatment, my family's and my participation may be required.

I also realize that sometimes treatment may result in a short term, temporary increase in previous problems or the appearance of new problems before things improve. I also realize that any behavioral change in a person or family results in both positive and negative consequences (gains and losses). I expect my therapist to help me understand and plan for this as part of treatment.

_____

Client's signature (Parent/Guardian ,if child) Relationship to client

_____

Witness/Therapist Date