

**CONSENT TO TREATMENT**

I authorize Willow Ann Rose LPC CHT NCC to provide psychotherapeutic and counseling services to me. I have read and if desired, discussed with my therapist, the contents of this document, including all Professional Disclosures, Financial Agreements, Insurance Information and Informed Consent. I understand I may request of my therapist at any time, further clarification of any part of this document or of any aspect of my treatment.

I affirm that my request for services is voluntary and that I may discontinue at any time. I affirm that I am responsible for payment of services rendered to me by Willow Ann Rose LPC CHT NCC. I have created my own copy, or my therapist has provided me a copy of this document so that I may retain this information for my own records. I willingly agree to abide by all guidelines as set forth in this document.

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Client Signature Date

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Full Printed Name

Form Revised: 1/15