Denise C. Wall, LCSW
610 Main Street | P.O. Box 514
Odessa, Delaware 19730
302-376-5259 Office
302-689-4474 Fax

CONSENT TO TREATMENT (Please print clearly)

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

I hereby seek and consent to take part in the treatment provided by *Denise C. Wall, LCSW*. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interested. I agree to play an active role in this process.

I am aware that I may stop my treatment with this therapist at any time. The only thing that I will still be responsible for is paying for the services that 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 to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged a late cancellation fee.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments that I receive. 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 full understand and agree with all of these statements.

_____ Date: _____
Signature of Client/Patient (or person acting on their behalf)

Printed Name: _____ _____
Relationship to Client/Patient
(if applicable)

I, Denise C. Wall, have discussed the issues above with the client (and/or his 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 full competent to give informed and willing consent.

_____ Date: _____
Denise C. Wall, LCSW

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.