Better Solutions
Counseling Center

General Consent to Treat

Client Name: _____ Today's Date: _____

I authorize and request Better Solutions Counseling Center therapist(s) to carry out psychological exams, treatment and /or diagnostic procedures that now, or during the course of treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request.

_____ _____
Client Signature Date

If client is a minor:

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Client

_____ _____
Parent/Guardian Signature Date

_____
Relationship to Client

_____ _____
Therapist/Witness Signature Date