Family & Personal Counseling Services
An Association of Licensed, Independent Professionals

CONSENT FOR BEHAVIORAL HEALTH SERVICE

Please Print

Name of Client: ____

Date of Birth: ____

I hereby acknowledge that I have given my consent to participate in a diagnostic assessment and counseling services if they are indicated. My clinician has informed me that I might be given a diagnosis and behavioral health service recommendations as part of the assessment process. I understand that I have the right to refuse any service that is recommended to me as a result of the assessment. I understand that if I have any questions regarding the counseling process or my privacy rights, I can contact my clinician.

____
Signature of Client

Date: ____________________________

** In Case of a Minor: I agree and give permission for my child to participate in a diagnostic assessment and counseling services, if they are indicated, with the following clinician: ____

____
Name of Parent/Guardian of Minor Client

____
Signature of Parent/Guardian of Minor Client

____
Signature of Clinician

Date: ____________________________

**Mental Health Services may be provided to minors fourteen years of age or older for not more than six sessions or thirty days, whichever occurs first, without a consent for treatment form signed by the minor's parent or guardian.

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