

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Sheila LeGrand, LMHC. These services may include psychotherapy, diagnostic assessments and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

Signature of Patient

Date Signed

Signature of Parent, Legal Guardian or Conservator

Date Signed

Signature of Witness (if appropriate)

Date Signed