Rees Chapman, Ph.D.
Licensed Clinical Psychologist

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CONSENT FOR TREATMENT

I,_____(parent) on behalf of _____ authorize and request that Rees Chapman, Ph.D, provide psychological examinations, treatment and/or diagnostic procedures which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between Dr. Chapman and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Date:_____ Client Signature:_____

Date:_____ Witness:_____