Consent for Treatment

I,_____, authorize and request that Charles Asher, D. Min, LMFT provide counseling services, diagnosis, treatment, and/or diagnostic procedures which now or during the course of my care as a patient are advisable. 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 the maximum potential benefit will occur with consistent attendance at regularly scheduled sessions and depends upon multiple factors, such as motivation, effort devoted to the work, as well as other life circumstances.

I have been informed in a general way of the nature of counseling, my psychotherapist's training and background, confidentiality and its limits, and our efforts to identify the presenting issues and potential direction for our work together.

Please note this addition.: Since I am opting out of being a Medicare provider, I will, nor will anyone I work with be able to bill Medicare for my services. Payment will be to me according to agreed upon fee in either cash or by check.

I have read and signed the forms made available to me and have read the website drcasher.com.

If I am concerned about some of my information, I have the right to ask that it not be used or shared for treatment or administrative purposes. I agree to advise Charles Asher of my concerns in writing. I understand that he will try to respect my wishes but is not required to agree on any limitations.

My signature below indicated that I have read and understand the **Consent for Treatment Form**.

Client
Signature_____Date_____