RASMUSSEN
COUNSELING

CONSENT TO TREATMENT

Name of Patient:_____

I (for) the undersigned do hereby voluntarily consent to evaluation, recommendation and/or treatment by **Rasmussen Counseling LLC.** I am aware that the practice of psychotherapy is not an exact science. As a consequence, I acknowledge that no guarantee has been made to me concerning the result of any evaluation or treatment which may be rendered. Further, I understand that evaluation and treatment may involve discussion of personal events in my own history which, at times can be discomforting and is at all times very personal.

Limitations on confidentiality:

I understand that my rights of confidentiality apply to communications with the therapist subject to the limitations as described below. Specifically, I understand that while mental health information is confidential there are exceptions. A Mental Health Provider is required to disclose confidential information without my consent under certain circumstances that include, but are not limited to the following:

- If I am evaluated to be a danger to myself or others.
- If I am a minor, elderly, or disabled person and the Provider believes that I am the victim of abuse or if I divulge information about such abuse.
- If a court order, other legal proceedings, or statue requires disclosure.
- If the patient is a minor, or parent has access to the medical record, unless limited by court order or discretion by the therapist.

I agree that this authorization will remain in effect for the duration of all medical services rendered, or until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original.

Communications: By signing this form I agree to authorize my therapist to communicate with me via text messages and email for purposes of coordination of care of my treatment.

_____

Signature of Patient/Guardian Date

_____

Signature of Witness Date