CONSENT FOR TREATMENT FORM

Marty J. Rein, PhD, MEd. LPC, CAS
Rein Therapeutic Counseling and Consulting
3555 Stanford Road, Ste., 209
Fort Collins, CO 80525
Phone: 970-829-7399

Name: _____ Date of Birth: _____Today's Date: _____
Address: _____ Phone: _____
Email: _____

I understand that the type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.
I understand that all information shared with the clinicians is confidential and no information will be released without my consent. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provide services. All professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

If I have any questions regarding this consent form or about the services offered, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me. I understand that I may stop treatment at any time.

Signature: _____ Parent/Guardian signature: _____

Complete the area below ONLY if you agree to provide us with consent to inform person/s approved by you; be sure to both fill in the contact information and to sign your name.

Name of Person/s: _____
Address:_____ Phone Number/s: _____

Conditions of disclosure: _____
_____

I have read the above and agree to release this information to the person/s named here.

_____ **YES** Your Signature: _____