Anxiety Treatment Center of Orlando
Jenifer A. Garrido, LCSW
719 Peachtree Rd, Ste 200
Orlando, FL 32804
407-925-6759

Consent for Treatment Form

- I acknowledge that I understand the nature of therapy/counseling services, and I have had all my questions answered fully.
- I do hereby seek and consent to take part in treatment with the therapist named below. I understand that my therapist must complete a thorough evaluation, and that this will include a diagnosis at the conclusion of the evaluation. This diagnosis will be discussed with me.
- I understand that developing and reviewing goals with this therapist is a vital part of the therapeutic process. I agree to play an active role in developing and adhering to these goals.
- I understand that no promises have been made to me regarding the outcome of my therapy. Again, it is my responsibility to complete homework assignments given between sessions. A realistic time frame of how long I will participate in therapy will be discussed during the evaluation.
- I am aware that I may choose to discontinue treatment at any time, however, 24 hours' notice is required to cancel all sessions, otherwise I am responsible for a cancellation fee (*see client information form). While my therapist understands that there are extenuating circumstances, I agree to make a responsible attempt to adhere to this policy.
- I understand that if I fail to pay for treatment, services will be discontinued, and referrals will be provided to allow me to continue my therapy elsewhere. Similarly, should my insurance company deny coverage, I am responsible for payment, or my treatment will be discontinued (*please see client information form).
- I acknowledge that any and all information disclosed during my treatment is confidential and will not be disclosed to any party, other than those required to pay for my treatment (insurance company). I understand that I am required to provide my signed consent to allow my therapist to disclose any information, including my status as a client, to any other individual.
- I understand that confidentiality will only be broken if:
    1. I indicate at any time to my therapist that I am a danger to myself or others, and failure to obtain additional treatment would result in harm; or
    2. A court order issued by a judge is received; or
    3. I have signed a Consent to Release Information Form.

By signing below, I agree to the above terms.

Signature of Client/ Representative	Date	Printed Name of Client/Rep	
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