heartsandmindshealth
licensed mental health services in NOVA and Metro DC

Informed Consent for Treatment

I, _____, do voluntarily consent to care and treatment by Michael Payne, MSW, LCSW, LICSW, who is licensed to practice Clinical Social Work in the District of Columbia, Florida, and Virginia. I understand that healing arts are not an exact science and that no guarantees are being made as to the result or evaluation of treatment.

I am aware that I am an active participant in my therapy and that I share the responsibility for the treatment process. Through the process of treatment I am working toward changes and recognize that I may experience many different and intense feelings as a part of this process, some of which may be painful. I also understand that when I make changes in myself, I may experience changes in other areas of my life (e.g., family, work, social life). Every change has the potential for both positive and negative outcomes.

I understand that our work will be kept strictly confidential with the exceptions of legal limitations on confidentiality.

I also understand that I can contact the nearest public emergency mental health service by calling **9-11** if I am unable to contact my therapist or their designee.

This form has been fully explained to me and I certify that I understand its contents.

Client Signature Printed Name Date

Co-Signature Date