Lisa A. Firullo M.Ed., LCMHC
704.763.0434

CONSENT FOR TREATMENT

Client Name: ______________________________
DOB: ________________

I agree and consent to participate in evaluation in treatment and I understand I may refuse services at any time. I understand my rights and responsibilities for services rendered by my provider. As a client of this practice I shall receive appropriate evaluation and treatment that may include individual counseling, education, or group therapy. This consent is valid until treatment is terminated.

Signature____
Date________________

Parent/Guardian Signature _____________________________
Date _______________

Witness____
Date________________