

Client Name:

DOB:

THE COUNSELING COLLABORATIVE
 Milja Brecher-DeMuro, MSW, LCSW
 1489 State Highway 102, Bar Harbor, ME 04509
 (207)288-3388

Consent To Treatment

Please initial below to indicate you have read and received copies of the following information:

_____ I have read and been given a copy of the Disclosure Statement for The Counseling Collaborative and Milja Brecher-DeMuro, MSW, LCSW.

_____ I have read and been given a copy of the Privacy Practices for The Counseling Collaborative and Milja Brecher-DeMuro, MSW, LCSW.

_____ I have read and been given a copy of and agree to the Technology Consent for The Counseling Collaborative and Milja Brecher-DeMuro, MSW, LCSW.

My signature indicates that I consent to treatment with Milja Brecher-DeMuro, MSW, LCSW and I have been informed of, given copies and agree with Milja Brecher-DeMuro, MSW, LCSW's Privacy Practices, Disclosure Statement, Admission Policies, Fees Schedule and Billing, my rights and responsibilities as a client and Technology Policies. I consent to therapeutic and/or diagnostic treatment to be provided by Milja Brecher-DeMuro, MSW, LCSW. I understand that I may withdraw my consent to treatment at any time. I am aware that the practice of psychotherapy is not exact science and acknowledge that no guarantees have been made to me as to the result of treatment by Milja Brecher-DeMuro, MSW, LCSW.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Counselor Signature: _____ Date: _____