

Arizona Body-Mind Counseling
Counseling Consent for Treatment

I hereby grant permission to Arthur L. Matthews, MA LPC to provide routine evaluation and brief treatment as may be deemed necessary or advisable for the diagnosis and/or care of

_____. I understand that this consent shall remain in effect as long as I
Client Name
am actively engaged in a therapeutic relationship.

I understand that all information gathered in the course of my treatment is confidential; however, information may be released without my consent in cases of emergency, abuse, neglect, court order, file audit by Arizona State Health Department and otherwise where legally required.

I agree to participate in my treatment planning process to the best of my ability. I understand that there is no guarantee these services will prove beneficial to me.

Client Name (Print)

Date

Client Signature

Counselor Signature

Date