

***Imagine Counseling  
Services, PC***  
**402-934-8976**

**Informed Consent for Treatment**

I give consent for an evaluation and treatment for myself/my child  
by \_\_\_\_\_.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risk, benefits, side effects, and alternative of treatment and the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time.

**\*\*** My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

\_\_\_\_\_ Signature of Patient or Parent/Guardian

----- ~~Printed Name~~ -----

----- Date

\_\_\_\_\_ Relationship to Patient (if applicable)

\_\_\_\_\_ Witness' Signature

----- Date