



**Devina Cruickshank Brown, LCSW**  
**Julie Chen, LMHC, CAP**

**INFORMED CONSENT FOR TREATMENT**

I hereby request that \_\_\_\_\_ born \_\_\_\_\_ and residing at \_\_\_\_\_  
Participant Name Date of Birth  
\_\_\_\_\_  
Street Address City State Zip Code Telephone Number

be accepted for mental health treatment as described to me.

1. I give my authorization and consent to receive outpatient diagnostic and treatment services from Creative Solutions 4 Kids and Families, LLC.
2. I have been given information regarding my rights and responsibilities as a participant.
3. I have been given information regarding the limits of confidentiality of my records.
4. I have been given information regarding the cost of services from Creative Solutions 4 Kids and Families, LLC. I understand that I am responsible to pay any fee not covered by my insurance provider. These fees are payable each time I come for treatment.
5. I understand that I may address any concerns or grievances with my therapist directly or with any other representative of Creative Solutions 4 Kids and Families LLC. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
6. I am freely choosing to enter into treatment, and I understand that I may discontinue treatment at any time.
7. I have been given information about the advantages and disadvantages of the treatment recommended as well as other alternatives.

\_\_\_\_\_  
Client Signature Date

\_\_\_\_\_  
Print Name

**PARENT OR GUARDIAN:**

I, \_\_\_\_\_, do hereby state that I am the natural parent or legal guardian of the participant; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in this form.

\_\_\_\_\_  
Signature of Guardian/Parent Date

\_\_\_\_\_  
Witness Signature Date

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