Focus Mental Health Services
905 E. Wilson, Shawnee, OK 74804
405-214-0116
www.focusmhs.com

INFORMED CONSENT FOR TREATMENT

Application is hereby made by the undersigned for voluntary admission to the services of Focus Mental Health Services, LLC (Focus MHS).

1. I authorize associates of Focus MHS to administer treatment (i.e. counseling, and/or neurofeedback) and continue such treatment as deemed professionally necessary.
2. I understand that this consent is given before any specific diagnosis or treatment is given. The professionals of Focus MHS exercise their judgment in determining the diagnosis, developing a treatment plan and in providing treatment.
3. I agree to be actively involved in the treatment plan as developed by the professional of Focus MHS. I understand that included in this treatment plan would be my involvement in regular individual, family or group therapy sessions as recommended.
4. No guarantees have been given to me as to the results that may be obtained.

PROPER USE OF SERVICES

1. I understand that the purpose of counseling is for the betterment of myself and/or my family. It is not intended to be used as a tool or weapon for divorce, custody, disability, or other litigation. If I request copies of my records or the testimony of my therapist for such purposes, there will be a separate financial fee for which I agree to be responsible.
2. If I request my therapist to testify on my behalf, I acknowledge the following fees will apply and must be prepaid prior to any such testimony being given:
    a. Licensure candidates - $1,000/day
    b. Licensed clinicians - $1,500/day
    c. Licensed supervisors - $2,000/day

ACKNOWLEDGMENTS AND SIGNATURE

I have read the consent for treatment and understand all of its contents and sign my name freely, voluntarily and without coercion.

Client Name (Printed)	DOB	ID Number (Medicaid)

Client Signature	Therapist Signature
Parent/Guardian Name (Printed)	Parent/Guardian Signature
Date	Date

File Name: _____