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**THE PROFESSIONAL DISCLOSURE STATEMENT AND CONSENT FOR
TREATMENT OF KEYSTONE COUNSELING AND CONSULTING, LLC.**

CONSENT FOR TREATMENT

I acknowledge that I have read and received copies of the two documents: The Professional Disclosure Statement and Consent for Treatment of Keystone Counseling and Consulting, LLC, and Client's Right Under HIPAA. My signature below confirms that I understand and accept the information in these documents. I further consent to treatment with my therapist (below). I understand that my participation in therapy or psychological testing is voluntary and that I may terminate services at any time. If I do decide to terminate, I will give my therapist at two-week notification. While I expect benefits from treatment, I understand that such benefits cannot be guaranteed. I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance or other third party payer.

Signature of Client

Date

Signature of Parent or Guardian (if client is a minor)

Signature of Therapist

Date

If more than one individual (e.g., couple or family) is seeking therapy, each individual's signature is required. Their signatures indicate they have read this form and consent to treatment. Additional copies will be provided upon request.

Signature of Client #2

Signature of Client #3

Signature of Client #4

Signature of Client #5