Stefanie Rosen, M.A., M.F.T.

MFC 39048

CONSENT FOR TREATMENT

I, _____, AUTHORIZE AND REQUEST THAT STEFANIE ROSEN, M.F.T. PROVIDE TREATMENT FOR _____. I UNDERSTAND THAT TREATMENT MAY CONSIST OF PSYCHOTHERAPY OR OTHER APPROPRIATE TECHNIQUES WHICH NOW OR DURING THE COURSE OF TREATMENT ARE ADVISABLE. THE FREQUENCY AND TYPE OF TREATMENT WILL BE DECIDED BETWEEN MS. ROSEN AND ME.

I UNDERSTAND THAT THE PURPOSE OF THESE PROCEDURES WILL BE EXPLAINED TO ME AND ARE SUBJECT TO MY VERBAL AGREEMENT.

I UNDERSTAND THAT THERE IS AN EXPECTATION THAT TREATMENT WILL BE BENEFICIAL, BUT THERE IS NO GUARANTEE THAT THIS WILL OCCUR.

I UNDERSTAND THAT MAXIMUM BENEFIT WILL OCCUR WITH CONSISTENT ATTENDANCE AND THAT AT TIMES I MAY FEEL CONFLICTED ABOUT MY THERAPY AS THE PROCESS CAN SOMETIMES BE UNCOMFORTABLE.

I UNDERSTAND THAT I CAN WITHDRAW CONSENT FOR TREATMENT AT ANY TIME.

I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FOR TREATMENT FORM.

_____ _____
SIGNATURE OF CLIENT(S) DATE

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

2277 Townsgate Road, Suite 200, Westlake Village, CA 91361 (818) 292-0331