Counseling and Psychological Testing
Consent for Treatment - Minor

Family Center by the Falls
8401 Chagrin Rd. Suite 14B
Chagrin Falls, OH 44023
(440) 543-3400

I hereby indicate that I have read, understand, and agree to all of the terms of the "Family Center By The Falls Policies and Procedures" available at our office in print or online at www.fcbtf.com. I hereby give my consent for the Clinical Staff of Family Center by The Falls to render psychological treatment and/or counseling services and care to the minor child named below, including the performance of diagnostic and therapeutic procedures deemed advisable and discussed with me. I am aware that participation in services is voluntary and I may limit or end services at any time. I understand I will be kept informed of the reasons for the treatment/procedure(s), along with the expected benefits, risks, possible alternative methods of treatment, and possible consequences involved.

I understand that I will be fully responsible for any and all charges at the current rates established by Family Center by The Falls for all services rendered to the individual named below. In the event that the balance due has to be collected by an outside agency or attorney, I agree to pay collection costs and attorney fees. This authorization may be revoked in writing at any time except to the extent those actions have been taken in reliance thereon.

I agree that all agreements and contracts between me and Family Center by the Falls and its staff are in writing and that there are no oral agreements between myself and Family Center by the Falls and its staff. Any modifications of the terms of this agreement must be in writing and signed by myself and my psychologist/counselor. This Consent for Treatment is a contract for services. I have carefully read and understand this contract. I agree that this is a legally binding contract. I agree that the provisions of this contract are reasonable, fair, equitable, and candid. I agree to this contract without undue influence, duress, or coercion from any source. I knowingly, willingly and without exception give my full informed consent to, and agree to abide by and be bound by, each and every one of the provisions contained herein.

Your signature below indicates that you have read and understand the "Family Center by the Falls Procedures" and consent to treatment for your minor child.

Name of Patient:____

____

Patient Signature (if appropriate)

Date

____

Parent/Guardian Signature

Date

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