

## Consent to Treatment

1. I hereby consent to receiving counseling and psychotherapy from Julie Hanson, a Licensed Clinical Social Worker (LCSW)
2. Knowing that my condition may require a mental health diagnosis and require treatment, I do hereby authorize and request treatment for the specific condition identified.
3. I hereby release Julie Hanson, LCSW from responsibility for any injury which results from my termination of treatment, against her advice.
4. I am seeking counseling of my own free will without coercion from any person or organization.
5. I have been informed that Julie Hanson, LCSW, is licensed by the state of Illinois to perform therapy with individuals, families or couples.
6. I have been informed that counseling is a collaborative process utilizing emotional, cognitive and behavioral processes to achieve the desired goals of treatment.
7. I have been informed that Julie Hanson, LCSW uses traditional and approved counseling techniques that will respect my values, beliefs, faith and relationships and do no intended harm.
8. Julie Hanson, LCSW has informed me of the benefits and risk of therapy and I am entering therapy with full knowledge that my anxiety depression and discomfort may increase before any relief is experienced and the desired goals may be reached with mixed results.
9. I have the right to withdraw my consent for information and agreement to treatment my informing my therapist in writing.

I have read the above statements and understand the content. I have asked questions to clarify what I do not understand.

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Client Signature

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Date