INFORMED CONSENT FOR SERVICES FOR CHILDREN/ADOLESCENTS

Client's Name:
Insurance Company:
Insurance ID#
Date of Birth:

I, _____ /
(Name of Guardian)/(Relationship)

of the above named client, herein do voluntarily consent for this child to receive mental health services (i.e. diagnostic assessment, therapeutic services, consultation) from BASICS Counseling Services LLC (hereafter referred to as BASICS).

I understand both the privileges and the requirements associated with the services being rendered by BASICS as stated in the Client's Bill of Rights. It is understood and agreed by all parties that, unless stated otherwise, this consent form will expire upon completion of services from BASICS. It is further understood that I may withdraw this Informed Consent For Services at any time and for any reason by filling out a Discharge Summary Form.

Your signature below indicates that you have read the information in this document, that you have understood it, and that you agree to abide by its terms as long as you are a client at BASICS Group Practice, LLC.

Client Signature **Date**

Parent/Guardian Signature (If Client Under 18 Years) **Date**

Clinician Signature **Date**

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