**INFORMED CONSENT FOR TREATMENT STATEMENT**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, birthdate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(Print Client Name)

have read and understand the above stated policies and procedures for psychotherapy services provided by Brenda J. Arley, MA, RNCS, LMFT. I understand that if I have additional questions or concerns regarding these policies and procedures that I will ask that they be addressed. I agree to the terms as stated in this document and give my informed consent for treatment.

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Signature of Client Date