4Directions Counseling
Mind. Body. Heart. Spirit.

Consent to Treatment

I, _____(client), hereby authorize _____ (herein Counselor) to provide professional services to myself/my child. I understand that the owner of 4Directions Counseling, LLC is Alexandra Milspaw, a Licensed Professional Counselor (License #PC006739). As such, I understand that the Counselor is qualified in the assessment and treatment of mental health and other problems in living, which can include individual, couples, family, or group therapy. I understand that the Counselor may recommend referral to another professional service provider if that is deemed to be in my best interest.

I consent to treatment and professional clinical practices with the Counselor freely of my own will if I am 14 years of age or older. I may grant authorization for a child of mine under the age of 14 to receive professional services. In matters of a child's treatment when that child's parents are separated or divorced and custody matters are at issue, I understand that both parents' rights will be respected, that the child will be considered the client, and that the Counselor shall treat the child from a stance of neutrality over the parents and in the best interest of the child. I understand that I may contact my managed care or insurance provider to obtain the names of other qualified professionals who may provide services to me.

_____ _____

Client's Signature **Date**

_____ _____

Client's Parent/Guardian Signature (under 14) **Date**

_____ _____

Client's Parent/Guardian Signature (under 14) **Date**

_____ _____

Counselor (witness) **Date**