CONSENT FOR TREATMENT

Client Name: ____ **Date of Birth:** ______________

Date of Evaluation: ___________________ **Clinician:** ___________________________________

Diagnosis: ____
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____
____

Recommended Intervention ***(schedule and frequency)*****:** ___________________________________
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____
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Recommended Treatment Goals: ____
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____
____

Restrictions and Risks: ____
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____
____

Benefits: ____
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____
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Informed Consent:
I have had the opportunity to participate in the development of treatment goals, interventions, and services. Should I have any questions related to my services at Innovations in Learning, I understand that I may ask at any time. All risks and benefits of the recommended interventions have been explained. I consent to participate in the services as described above.

_____________________________________ _____________________________________
Client/Guardian Signature Witness Signature

_____________ _____________
Date Date