Consent to Treatment

I voluntarily agree to receive mental health assessment, care, treatment or services and authorize Donna M. Firer, LCSW - C to provide such care, treatment, or services as are considered necessary and adequate.

I understand and agree that I will participate in the planning of my care, treatment, or services and that I may stop and discontinue services at any time.

By signing this Consent to Treatment, I, the undersigned, acknowledge that I have both read and understand the office policies and procedures. I specifically understand the procedures for billing and payment of services; cancelling appointments and charges for same; use of email and texting, and client privacy.

I understand that Donna M. Firer, LCSW - C will follow laws governing confidentiality when there is concern related to lethal danger to self or danger to others. In addition, other risky behaviors involving self harm; use of alcohol and other chemical substances; maltreatment of vulnerable populations such as the elderly, those with mental illness or developmental delays, etc.; and other topics of concern are always taken very seriously. In such cases, there is an effort to carefully assess whether other professionals can be brought in to serve as resources.

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Signature of Client/Parent Date

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Donna M. Firer, LCSW - C Date