MN COUNSELING AND THERAPY CENTER

Erin Shobe, M.A., LMFT, RPT-S
Molly Nepote, M.A., LAMFT
Melissa Tyler, M.A., LAMFT
Olivia Newstrom, M.A., MHP

Informed Consent for Treatment

I give consent for evaluation and treatment to be provided for myself/my child by either **Erin Shobe**, M.A., LMFT, RPT-S, **Molly Nepote**, M.A., LAMFT, **Melissa Tyler**, M.A., LAMFT, or **Olivia Newstrom,** M.A., Mental Health Practitioner.

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

Information on the risks, benefits, and alternatives of treatment have been made available to me through the *Introduction to Therapy* documents, and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself/my child to my clinician so that I/my child will receive effective treatment. I also agree to play an active role in the treatment process.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all the above statements. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign the consent.

_______________________________________ _____________
Signature of Client or Parent/Guardian Date

____
Printed Name

____
Relationship to Client (if applicable)

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