Jessica Sauer, LCSW
Brand New Day Counseling, LLC
924 North Magnolia Avenue #350 Orlando, FL 32803
Phone: (407) 733-5392 • Facsimile: (407) 386-8237
www.brandnewdaycounseling.net

TREATMENT CONSENT FORM

This form must be completed and signed by both parents if a minor is being seen and parents are divorced or separated prior to meeting with therapist.

Client Name:_____ Date:_____

Client Date of Birth:_____

Explanation of Consent Form:

This treatment consent form covers all interventions that are not of a nature to require a special consent, and it provides protection for the interventions performed by the therapist. This form documents that the client or client's representative has consented to treatment with Jessica Sauer, LCSW, including but not limited to psychotherapy, counseling and coaching. This allows the therapist to provide services to the named client. This form provides evidence that no guarantee is made by the therapist concerning the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by the therapist. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

Consent to Treatment:

I, _____for_____,
(Print Your Name as a Consenting Adult) (Print Name of Client)

do hereby voluntarily consent to care and treatment by Jessica Sauer, LCSW. I am aware that the practice of counseling and therapy is not an exact science and acknowledge that no guarantees have been made as to the result of evaluation or treatment. I am aware that I am an active participant in the counseling process and that I share responsibility for my treatment. My responsibilities in treatment include informing the therapist of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way. I understand that insurance payment for mental health visits is based upon medical necessity, meaning that I have a mental health diagnosis which becomes a permanent part of my medical record, and my insurance company may seek to verify this diagnosis and services provided by mandating disclosure of my progress notes. Conversely, I understand that if I pay privately, additional privacy rights are maintained, since my records will not be provided to a third party for verification of services. If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

Effective 08/11/2021

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This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Signature _____ Date _____

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