Susan V. Sims, LMHC, MCAP
3502 Henderson Blvd; Suite 205; Tampa, FL 33609

CONSENT FOR TREATMENT

I have chosen to receive treatment services. My choice has been voluntary and I understand that I may terminate treatment at any time. I understand that the sessions last 50 minutes.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and me, I know I must work with my therapist to achieve the therapeutic goals. I understand that during the course of my treatment, material may be discussed which could be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that I may be contacted by my insurance carrier to ensure continuity and quality of my treatment, and/or after the completion of therapy, to assess the outcome of treatment.

I hereby give consent to Susan Sims, L.M.H.C. located at 3601 W. Azeele Street, Tampa, FL 33609, and/or her associated staff to provide the necessary diagnosis and treatment of the personal or interpersonal situation for which I am seeking help.

I have read and understand the above.

_____
Print Patient Name

_____ _____
Signature of Patient Date