Todd S. Larsen, Ph.D.
Licensed Psychologist

Informed Consent for Treatment Signature Form

This form is to document that I, _________________, have read the detailed informed consent document provided (see attachment) and give my permission and consent to Todd S. Larsen, Ph.D. to provide psychotherapeutic treatment/assessment (circle appropriate one or both) to me and/or
_____________________________ who is/are my (spouse/child/children) ___________.

While I expect benefits from this treatment, I fully understand that because of factors beyond our control or other factors, outcomes cannot be guaranteed (as detailed in the attached).

I understand this treatment may involve discussing relationships, psychological, and/or emotional issues that may at times be distressing. However, I understand that this process is intended to help me personally and with relationships. I am aware of alternative treatments available to me.

Dr. Larsen has answered all of my questions about treatment satisfactorily. If I have additional questions, I understand that he will either answer them or attempt to find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with Dr. Larsen.

I have read and understand the above information.

____ ________________
Client/Responsible Party Date

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