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370 Queens Ave, Suite 100

London ON N6B 1X7

Phone: (519) 936-0108 Fax: (519) 936-1028

**Signature of Consent to Treatment**

I, voluntarily, agree to myself and to my child (insert child’s name if applies) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_receiving mental health services, assessment, care or treatment, and authorize the undersigned therapist to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my child’s treatment or services, and that I may stop such treatment or services that my child and I receive through the undersigned therapist at any time.

By signing this Consent form, I, the undersigned client acknowledge that I have both read and understood all the terms and information contained in the Client Information and Consent form and may request a copy of such. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

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Client’s Signature Date

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Print Name

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Client’s Signature Date

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Print Name

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Child Client over 12yrs Signature Date

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Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist’s Signature Date