Michele L. Criddle, MA, LMFT-A, LCDC
Criddle Counseling Services
PO Box 1643
Crosby, TX 77532-1643

Phone: 832-584-3565

TX LCDC License # 12985
TX LFMT-A License # 202696
NPI #1861851495

Consent to Treatment

I, _____, do hereby seek and consent to take part in the treatment with Ms. Michele L. Criddle, LMFT-A, LCDC, with Criddle Counseling Services. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop treatment with Ms. Criddle at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of the statements.

_____ _____
Signature of Client (or person acting for client) Date

_____ _____
Printed Name Relationship to Client (if applicable)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Signature of Therapist Date