

ANCHOR COUNSELING
Informed Consent To Treatment

I (we), the undersigned, do hereby give my consent to the receipt of therapy. I understand that the treatment will involve:

- (1) my explanation of the problem and the changes I wish to make,
- (2) new perspectives on the problem offered by the therapist, and
- (3) dialogue regarding possible solutions.

I have made my decision to receive this treatment voluntarily and freely.

I appreciate that there are certain risks associated with this therapy including but not limited to increased emotional distress and increased anxiety or depression. I also understand that there are possible benefits associated with this therapy including:

- (1) increased peace of mind, and
- (2) positive changes in my behavior.

However, I understand and appreciate there is no certainty that I will receive these benefits, and no guarantee has been made to me regarding the outcome of this procedure.

I understand that there are other, reasonable alternatives or additions to this therapy including:

- (1) psychotropic medication prescribed by a physician,
- (2) seeking the counsel of another person, e.g. my pastor or priest, or
- (3) doing nothing or simply waiting for change to occur spontaneously.

I understand that I have the right to ask questions about my treatment at any time. If I am dissatisfied, I have the right to talk to the clinician that works with me about my dissatisfaction, and if problems cannot be resolved, I have the right to talk to a supervisor. At this time, all my questions regarding my therapy have been answered to my satisfaction. I am authorizing my therapist, Dr. James Robert Ross, to perform this therapy. I understand that he will consult with other health care professionals as he considers necessary for my care. I agree to their participation in my care I understand that my participation in treatment is voluntary, and that I may withdraw from treatment at any time.

I (we) have read this form fully and completely, I (we) have discussed any questions I (we) had about the information contained in this form, and I (we) understand the information contained in this form. I (we) understand that there are no guarantees stated or implied, and I (we) accept the risks inherent in the course of therapy. My (our) signature below acknowledges my (our) understanding and agreement to the information above, and that I (we) grant Dr. James Robert Ross permission to perform the professional procedures deemed appropriate for treatment of the following named patient(s):

Signature _____ Date _____

Signature _____ Date _____