



# AUTHORIZATION FOR TREATMENT

I acknowledge that I have received, have read (or have had read to me), and understand the following:

- Moosilauke Counseling Solutions Practice Information
- Moosilauke Counseling Solutions Notice of Privacy Practices
- Moosilauke Counseling Solutions Cancellation Policy
- Moosilauke Counseling Solutions Telehealth Informed Consent
- Moosilauke Counseling Solutions Client Financial Responsibility Agreement
- Moosilauke Counseling Solutions Prescription History Release

I understand the information about the treatment and/or therapy I am considering. I understand that there have been no promises or guarantees made to me as to the results of treatment and/or therapy. I understand that there are some risks as well as many benefits with treatment and/or therapy. I understand that Moosilauke Counseling Solutions does not have providers/clinicians available after hours or on weekends.

My signature below indicates that I understand the information about the treatment and/or therapy and that all my questions have been answered to my satisfaction. I agree to the terms, and I hereby consent to receive services from Moosilauke Counseling Solutions and agree to take an active role in my treatment.

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Client Signature

Date

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Legal Guardian Signature (required for minor age clients)

Date