TREATMENT CONSENT

I, the undersigned, hereby authorize The Family Wellness Center to perform health evaluations for the purpose of designing an individualized wellness program to enhance my health. Under the Ninth Amendment of the Constitution of the United States of America, I retain my freedom of choice in health care. This includes the right to obtain, purchase and use therapy, regime, remedy or product recommended by the health practitioner of my choice.

The undersigned understands

Deborah Coulston, MA, MATS, LMFT is an experienced professional psychotherapist, licensed marital and family therapist, expressive arts therapist, and behavioral addiction specialist.

I understand the nature and risks of all therapies including alternative therapies and the possible complications. I further understand that there is no implied or stated guarantee of success or effectiveness of any specific therapies obtained through The Family Wellness Center nor are they intended to be a substitute for regular medical care. I may choose to use alternative or integrative therapies as a complement to my regular medical program, and will not discontinue any medication or treatment without the approval of my existing Primary care physician. I agree to seek additional medical attention as necessary regarding any and all medical conditions, and if I choose no other form a care, I take full responsibility for my state of health.

I understand that I will be responsible for payment in full at time of service. Cash, check, debit cards, and major credit cards are accepted as forms of payment.

I have had my questions regarding this consent form answered to my satisfaction. I will ask for further clarification of therapies as necessary.

Name (please print):_____

Signed:_____ Date:_____

Witnessed by:_____ Date:_____