Crawford Consulting and Mental Health Services, INC

"Healing Life through the Experience of Living"

CONSENT FOR TREATMENT

CLIENT NAME ______________________________

I hereby authorize **Crawford Consulting & Mental Health Services, INC** and designated staff members as may be selected to perform the following procedure(s):

Check all appropriate procedures:
(A) Individual Therapy ( )
(B) Play Therapy ( )
(C) Family Therapy ( )
(D) Couples Therapy ( )
(E) Psychological Testing ( )
(F) Comprehensive Assessment ( )
(G) Grief Counseling ( )
(H) Pre-Marital Counseling ( )
(I) Group Therapy ( )
(J) Psychiatric Assessment ( )
(K) Community Based Intervention ( )
(L) Parenting Classes ( )
(M) Other ( )____

I hereby consent to the services rendered by Crawford Consulting and Mental Health Services, INC and the general services provided by its' practitioners. I also acknowledge that no guarantee or warranty has been made as to the result of any therapy which may be given or performed.

_________________________________ _________________________
Signature of Client or Legal Guardian Date

_________________________________ _________________________
(Signature of Witness) Date

6490 Landover Road, Suite F
Cheverly, MD 20785
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