

**Cynthia Weston, MS, LMFT 42043**

16055 Ventura Blvd. #420, Encino, CA 91436  
2660 Townsgate Rd. #530 Westlake Village, CA 91361  
PH: 818-347-2600

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_, authorize and request that Cynthia Weston, LMFT, provide treatment and/or diagnostic procedures, which now or during the course of my care as a patient are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment Form.

Date: \_\_\_\_\_ Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

**CONFIDENTIALITY:** I am required by the Board of Behavioral Science Examiners to keep session notes, and if subpoenaed, I may be Legally obligated to release client files. All information disclosed within sessions including that of minors, is confidential and may not be revealed to any one without written permission except where disclosure is permitted or required by law. Disclosure may be required in the following circumstances:

- a. When there is a reasonable suspicion of child abuse to a dependent or elder adult.
- b. When the client communicates a threat of bodily injury to others.
- c. When the client is suicidal.
- d. Physical injury due to violence.
- e. When disclosure is required pursuant to a legal proceeding

**OTHER RESOURCES:** I am available to share with you other resources including reading material, service organizations, health practitioners, attorneys, educational support services, etc. Please feel free to ask for these resources with the knowledge that I cannot be held responsible for the quality of other professionals' services and that these services and professionals are not affiliated with Cynthia Weston, M.S, L.M.F.T.

I understand that the purpose of the procedures will be explained to me and subject to my verbal agreement. I have read and fully understand this Consent for Treatment Form.

Client Signature/Date \_\_\_\_\_

Responsible Payor Signature/Date \_\_\_\_\_