Healing Day Counseling&Psychotherapy

797 Washington Street Suite 4 Newtonville, MA 02460 phone: 617-820 8895

Consent to Treatment

1. I _____ (patient name) give my informed consent **Cigdem Kilic Betebenner, MA, LMHC** to treat me.

2. I allow **Cigdem Kilic Betebenner, MA, LMHC** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Cigdem Kilic Betebenner, MA, LMHC** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all other treatment alternatives with my provider.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian Signature Date
(for children under 18)

_____ _____