

Mel Gardner, MC, LPC  
14358 N. Frank Lloyd Wright Blvd., Ste. 3  
Scottsdale, AZ 85260  
480-477-6763

Please read this form and bring it to your first session with any questions. Please **Do Not Sign** this form until you have discussed it with your counselor. **Thank you.**

## Consent To Treat

I, the undersigned, do hereby agree and give my consent for treatment by Mel Gardner, MC, LPC and I hereby request and authorize the above licensed professional counselor to provide such care and administer such diagnostic, and/or therapeutic procedures and treatments as, in the judgment of the above counselor is deemed necessary or advisable in my care or in the care of my family. I certify that I have read and understand this form and that no guarantees have been made to me as to the results of treatments done.

By signing this consent, I agree to report any suicidal or homicidal thoughts to the above counselor, and agree to use the phone coaching and crisis numbers provided. I hereby agree that should my suicidal or homicidal thoughts intensify to the point that I feel no longer able to refrain from acting on them, that I will call for skills coaching and utilize the coaching to the best of my ability **or call 911** before taking action. I understand that in the case where a skill coaching was insufficient or where I felt unable to utilize the skills to stay safe, that I will inform the above counselor and that she may suggest I enter a hospital at that time for my protection or for the protection of another. I understand that in such a case, I will be asked by my counselor to voluntarily agree to hospitalization, and that if I refuse admission my counselor may act to keep me safe by contacting the public mental health authority or the local police department. I hereby declare that I understand that should I choose to act on suicidal or homicidal thoughts without first reporting them as described above, or without allowing myself to be hospitalized, that I will have violated this consent and my counselor may choose to discontinue therapy or refer me to another mental health professional.

I acknowledge responsibility for all charges incurred by me or by any other that I am responsible for, due to counseling services provided. I understand that payment is due on the same day that services are rendered.

I acknowledge that I have reviewed and discussed this document with Mel Gardner, MC, LPC.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date