



***Coral Gables, FL 33146 • Tel: 786-531-8841 • Email: selfexpressionstx@gmail.com***

## **Consent for Services**

☐ I authorize Self-Expressions Therapy to render appropriate evaluation and therapy services to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time by Self-Expressions Therapy in writing. In addition, Self-Expressions Therapy may terminate services by notifying me in writing.

☐ I do not give my consent or am withdrawing my consent regarding Self-Expressions Therapy rendering evaluation and therapy services to the client named below.

\_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Client Date of Birth

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Relationship to Client