Consent to Treatment

Sabrina Walters Counseling, LLC
3000 NW Stucki PL Suite 230
Hillsboro, OR 97124

I, _____ certify that I have fully discussed with my counselor the circumstances and problems which caused me to seek assistance from Sabrina Walters Counseling, LLC. I understand that my counselor will fully discuss with me any anticipated changes in my treatment before making those changes. I also have received a copy of Sabrina Walters Counseling, LLC Personal Disclosure Statement and Privacy Policy, which specify my rights as a client of Sabrina Walters Counseling, LLC.

I hereby authorize Sabrina Walters Counseling, LLC and her billing representatives, MHBC to apply for insurance benefits on my behalf for covered services rendered by Sabrina Walters Counseling, LLC. I authorize payment of medical benefits from my insurance company be made directly to Sabrina Walters Counseling, LLC. I authorize the release of any medical information necessary to process this claim. I certify that the information that I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing.

Date _____ Client's Signature_____

Date _____ Client's Signature_____

Parent's Signature (if required) _____Date_____

Therapist's Signature _____ Date_____