



CONSENT FOR TREATMENT

I voluntarily agree to receive a mental health and medical health assessment, substance use disorder treatment, co-occurring disorders treatment, and discharge/aftercare planning by the staff of PathLight Counseling to take place primarily on the grounds of the facility located at:

PathLight Counseling
4390 Earney Rd. Suite#140
Woodstock, GA 30188

I understand and agree that I will participate in my treatment plan, and that I may discontinue treatment and/or withdraw my consent for treatment at any time.

I have read this Notice on the date indicated below.

Print: Client or Guardian

Signature: Client or Guardian

Date

NOTE: All information developed during the course of my treatment is Protect Health Information as defined by Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and PathLight Counseling is a covered entity of this rule.