Yaron M. Peer, LCSW
1133 Broadway
5th Floor, Suite 521
New York, NY 10010
(347) 762-2713

Consent to Treatment

I do hereby seek and consent to take part in treatment with Mr. Yaron M. Peer. I understand that developing a treatment plan with Mr. Peer and participating in regular weekly sessions are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made as to the results of treatment or of any procedures provided by Mr. Peer.

I am aware that I may stop my treatment with Mr. Peer at any time. My only responsibility is paying for the services I have already received. I understand that if payment for the services I receive here is not made, Mr. Peer may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature of client Date

_____
Printed name

I, Mr. Yaron M. Peer, have discussed the issues above with the client. My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____
Mr. Yaron M. Peer, LCSW. Date

This is a strictly confidential medical record. Re-disclosure or transfer is prohibited by law.