

**Good Thoughts Services, PLLC  
Consent to Treat Form**

1. I \_\_\_\_\_ (Client/Member/Guardian of person) give permission for Good Thoughts Services, PLLC to provide medical and/or psychiatric treatment.
  
2. I allow Good Thoughts Services, PLLC to file for insurance benefits to pay for the care received.

I understand that:

- Good Thoughts Services, PLLC will have to send member's medical record information to their insurance company.

3. I understand:

- Client/member/guardian of person has the right to refuse any procedure or treatment.
- Client/member/guardian of person has the right to discuss all medical treatments with my clinician.

\_\_\_\_\_  
Client/Member/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name