Informed Consent for Treatment Cheat Sheet

Reviewed by the BastionGPT Clinical Advisory Board · August 2026

An informed consent for treatment form is the intake document where a therapist explains the nature of therapy, its risks, benefits, and alternatives, fees, and the limits of confidentiality, and the client agrees to treatment, usually by signature. Review it together before care begins and re-review when modality, fees, or confidentiality terms materially change. Most forms run 800 to 2,000 words in plain language.

Practice and clinician identification who is providing care
Do: record name, license type and number, contact details; pre-licensed clinicians add supervised status and the supervisor's name.
Pitfall: an associate's form that never names the supervisor; a board reads the omission as concealment of trainee status.

Nature and course of services describe this client's treatment
Do: state your approach, session length and frequency, the expected course, and that outcomes are not guaranteed.
Pitfall: one boilerplate modality description reused by every clinician; the clause must describe this client's actual treatment.

Risks, benefits, and alternatives both sides of the ledger
Do: name likely benefits, risks such as temporary distress, and alternatives: another approach, medication, a group, or none now.
Pitfall: benefits-only drafting; a form without risks and alternatives documents a partial disclosure.

Limits of confidentiality the clause the form exists for
Do: name the exceptions: abuse or neglect reporting, serious threat of harm, court orders, consultation, insurer access.
Pitfall: the vague version is the version boards discipline; wording must track your state's statutes, not a national template.

Communication, emergencies, and after-hours what happens in a crisis
Do: state how clients reach you, response times, the email and text policy and its limits, and the crisis plan.
Pitfall: a phone number with no after-hours plan; that gap is where an availability complaint points first.

Fees and billing pointer one source of truth
Do: state that fees, missed-session charges, and insurance terms live in the financial policy provided with this form.
Pitfall: pasting the full fee schedule here; every fee change then strands a stale signed version in the chart.

Client rights, refusal, and withdrawal what makes consent voluntary
Do: the client may ask questions, decline any technique, seek a second opinion, and end treatment at any time.
Pitfall: consent language that reads like a commitment to finish treatment; freedom to withdraw keeps consent voluntary.

Consent statement and signatures date the disclosure
Do: a short statement that the client read the form and agrees, dated signature lines for both, space for re-reviews.
Pitfall: an unsigned, undated form in the chart; in Colorado that becomes a statutory violation after the second visit.

Before the client signs

- [ ] Exceptions named, in your state's terms
- [ ] Right to decline, second opinion, stop anytime
- [ ] Re-review promised at material changes
- [ ] Fees live in the financial policy, not here
- [ ] Plain language a client can parse
- [ ] Client and clinician signatures both dated

Drafting with AI

Give it bullets about your practice: state, discipline, modalities, session logistics, communication policy, and how fees are handled.

"Draft a plain-language informed consent form: Colorado LPC solo practice, CBT, weekly 50-minute sessions, voicemail returned within one business day, fees in a separate financial policy."

Never paste client-identifying information into consumer AI tools. BastionGPT is HIPAA-compliant with a BAA on every plan.

800 to 2,000 words	90 to 180 min by hand	At intake, before care begins	Client · boards · auditors
typical length	clinical team estimate	when it is signed	who reads it

Informed Consent for Treatment Template

Copy or print for your practice · Adapt fields to your organization's, payer's and jurisdiction's documentation requirements.

Practice: Phone:

Clinician: License type/#:

If pre-licensed, supervised by (name and license):

1. Services

Approach, session length and frequency, expected course. Outcomes are not guaranteed; progress is reviewed with the client.

2. Risks, benefits, and alternatives

Possible benefits · possible risks, e.g., a temporary increase in distress · alternatives discussed: another approach, a medication evaluation, a support group, or no treatment now

3. Limits of confidentiality

Check each exception discussed; wording must track your state's statutes

- ☐ Suspected abuse or neglect of a child or vulnerable adult
- ☐ Serious threat of harm to self or others
- ☐ Court order or other legal requirement
- ☐ Professional consultation and supervision
- ☐ Information shared with an insurer when insurance is billed

State-specific duties:

4. Communication and emergencies

Between-session contact and expected response time, the email and text policy and its privacy limits, and the emergency plan

5. Fees and billing

Fees, missed-session charges, cancellation terms, and insurance are in the financial policy, provided separately.

- ☐ Client received the financial policy

6. Client rights

The client may ask questions at any time, decline any technique, seek a second opinion, and end treatment at any time.

7. Consent

I have read this form, had my questions answered, and consent to treatment as described.

Client (or guardian) signature: Date:

Clinician signature and credentials: Date:

Consent re-reviewed (date/initials):