BARBARA ANN CAUDILL, MSS, LCSW
180 PROVIDENCE ROAD, SUITE 9
CHAPEL HILL, NC 27514

INFORMED CONSENT FOR SERVICES

I, _____

CONSENT TO RECEIVE THE FOLLOWING SERVICES BY BARBARA ANN CAUDILL, MSS, LCSW:

_____.

I understand that my therapist will aide by all tenets of confidentiality and will release/obtain information only with my permission-except in the following situations:

– with my written consent
– if reported by the mandatory reporting law for suspected child abuse or neglect.
– in the event I present a danger to myself or someone else.
– in the event the counselor and/or case records are subpoenaed.
– When the counselor is consulting with another professional, making every effort to avoid revealing my identity, and with the understanding that the consultant will uphold confidentiality.
– for the purpose of reminding me of my appointments

I have read this form, had it explained to me, and had the opportunity to ask questions.
I understand the contents. By signing this document I agree to all of the above conditions.

Signature:_____Date:_____

Counselor:_____Date:_____