Brooke Schmaling, LCSW
180 Providence Road, Suite 9
Chapel Hill, North Carolina 27514
Telephone: 203-671-0275

Permission to Provide Services

I, _____, patient/parent/legal guardian of

_____, do knowingly enter into

agreement with and authorize Brooke Schmaling, LCSW to provide counseling and

psychological services to _____. These

services may include psychological assessment, developmental assessment, counseling,

individual, group and/or family psychotherapy.

I understand that I have the right to decide (for self or child) not to enter therapy (although depending on my situation there may be legal or other consequences for not entering or completing therapy), not to participate in any particular type of therapy, and to terminate therapy at any time. If I wish to terminate therapy here and continue therapy elsewhere, I will be given a list of providers with whom I can continue.

I understand that I have the right to complete and accurate information about my (or child's) treatment plan, goals, methods, potential risks and benefits, and progress. I understand that I have the right to request a summary of my treatment, including diagnosis, progress in treatment, prognosis, and discharge status.

Patient/Parent/Guardian's Signature___ _____ Date_____

Therapist Signature_____ Date_____