



CW Counseling & Consulting, LLC
Acknowledgment of Informed Consent

CW Counseling and Consulting, LLC
2400 Second Loop Road
Florence, SC 29501
Phone: (843) 667-1905 Fax: (843) 667-1723

Acknowledgment of Informed Consent

Name _____ Date _____

Date of Birth _____ Social Security # _____

Address _____

I acknowledge that I have received, read, and been allowed to ask questions about the Professional Disclosure Statement, Consent for Treatment & Confidentiality Policy, the HIPAA Notice, and Patient's Rights Information. I further acknowledge that I seek and consent to treatment for a minor child or myself. My signature below confirms that I understand and accept all the information in these documents.

Signature of Patient _____ Date _____

Signature of Counseling Staff _____ Date _____

Other Participants in Counseling Services

Family Member: _____ Initials: _____

Restrictions: _____

Family Member: _____ Initials: _____

Restrictions: _____

Teacher: _____ Initials: _____

Restrictions: _____

Other School Staff: _____ Initials: _____

Restrictions: _____

Other: _____ Initials: _____

Restrictions: _____