GLENISE PARROTT, LCSW
1122 Sam Newell Road
Suite 106
Matthews NC 28105

INFORMED CONSENT FOR TREATMENT

Client Name: _____

DOB: _____

I _____(name of client), agree and consent to participating in behavioral healthcare services offered in person or via Telehealth and provided by Glenise Parrott, LCSW, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that Glenise Parrott. LCSW is qualified to provide within the scope of her license, certification and training.

If the client is under the age of eighteen or unable to consent for treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Signature Date

_____

Relationship to Client (if applicable)