

PRESBYTERIAN COUNSELING CENTER

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CONSENT TO RECEIVE TREATMENT

I give my consent to receive counseling at the Presbyterian Counseling Center.

I accept financial responsibility for every appointment I make, and I agree to pay for each session each time service is rendered.

I agree to pay for any missed appointments for which I do not give 24 hour notice of cancellation.

I acknowledge I have received copies of the Center’s Notices of Privacy Practice (Brief and Complete), and I have been given opportunity to ask questions about these Notices.

Signed _____ Date _____

Witness (Administrative Assistant or Counselor) _____

Parental/Guardian Consent (If client is under age of 18):

I _____ certify that I have legal custody or that I am the legal guardian for medical consent purposes of _____. I give permission for him / her to receive treatment.

Parent/Guardian _____ Date _____

Witness (Administrative Assistant or Counselor) _____