Angela Ray Smith, LPC
703 Thimble Shoals Blvd., Suite A-3
Newport News, VA 23606
PH: 757-596-7938 ~ FAX: 757-596-7939

CONSENT FOR EVALUATION/TREATMENT

I, _____, consent to a psychological evaluation by Angela Ray Smith, LPC.

I understand that these evaluation/treatment services have been requested to aid in the diagnosis, evaluation, and treatment of: myself or _____. I understand these procedures may include interviews, observations, assessment, and/or therapy sessions. I understand the results of these procedures are confidential and will be released only to the referring party except in the event that I give specific written consent to release the results to another specific individual or agency named by me.

I also give permission for the administration of emergency medical treatment, should it be needed, while I am undergoing assessment or treatment w/ Ms. Smith.

I understand that I will be charged for the professional time spent in the course of my receiving evaluation/treatment services. I agree that I will not hold Ms. Smith responsible for any unforeseen consequences resulting from my evaluation/treatment.

I hereby certify that I have read and fully understand the above authorization.

_____
CLIENT SIGNATURE DATE

_____
WITNESS SIGNATURE DATE

_____
CLIENT SIGNATURE (For minor or otherwise appointed to sign for subject) DATE

_____
RELATIONSHIP TO CLIENT