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The therapist and I have discussed my/my child's case and I was informed of the risks, approximate length of treatment, and possible consequences of treatment, which includes the following methods and interventions:

For the purpose of:

- Stabilization
- Decrease and relieve symptom logy
- Improve coping, problem solving, and use of resources
- Skill development
- Grief resolution
- Stress management
- Behavior modification and cognitive restructuring
- Other

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

I understand that regular attendance will produce the maximum possible benefits but that I or we am/are free to discontinue treatment at any time in accordance with the policies of the office.

I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats to harm myself or another person.

I am not aware of any reason why I/we/he/she should not proceed with therapy and I/we/she/he agree to participate fully and voluntarily.

I have had the opportunity to discuss the aspects of the treatment and therefore, I agree to comply with treatment and authorize Judy Fisher to administer treatment to my child or me.

Name of Patient: \_\_\_\_\_

Signature or Patient/Parent or Guardian: \_\_\_\_\_

Therapist: \_\_\_\_\_ Date: \_\_\_\_\_