Aracoma Smith, LCSW, PLLC

Licensed Clinical Social Worker

3715 Latimers Knoll Court

Suite 106

Fredericksburg, VA 22408

PH: (540) 361-1844

PATIENT NAME:_____

I, _____, agree to participate in behavioral health care services provided by Aracoma Smith, LCSW, PLLC for myself or the patient listed above for whom I am the legal guardian and have the legal authorization to consent for treatment for this individual. I have reviewed "What to Expect in Psychotherapy" and have had all of my questions answered.

I understand that I am consenting and agreeing only to the services that the above named provider is qualified to provide within the scope of the providers license, certification, and training.

In addition, I am recognizing that the above provider has reviewed the following policies with me and I am agreeing to them. A written copy of these policies was also offered to me.

POLICIES REVIEWED: Appointments, Billing, Phone calls/E-mail, Court Appearances, Letter Requests, Confidentiality, and Termination.

Client/Patient Signature:_____ Date:_____

Parent/Legal Guardian Signature:_____ Date:_____

Witness:_____ Date:_____