

# CATAWBA COUNSELING ASSOCIATES, PLLC

Sharon Pendergast, MSW  
Victoria Grantham, MSW

100 Glenway Street, Suite B  
Belmont, North Carolina 28012  
(704) 829-2005

## CONSENT FOR UTILIZATION OF PSYCHIATRIC SERVICES

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

Patient: \_\_\_\_\_

I hereby voluntarily consent to utilizing the services provided by Catawba Counseling Associates, PLLC. Services include: assessment, consultation, individual, marital and family therapy.

I am aware that Sharon Pendergast, MSW, and Victoria Grantham, MSW, are licensed by the State of North Carolina, as clinical social workers.

As a patient utilizing the services of a therapist, I understand that I have the right to ask any questions I may have about the process, methods, duration and goals of treatment; the right to discuss any concerns I may have about my progress in treatment; and the right to terminate treatment if I feel I am not making progress.

I understand that one of my important rights involves confidentiality. Within certain limits, information revealed by me during treatment will be kept strictly confidential and will not be revealed to any other person or agency without my written permission. I understand that there are certain limits to confidentiality in which it is required by law and/or professional ethics that any therapist reveal information obtained during treatment to other persons or agencies without my permission. These limits to confidentiality are as follows:

(a) if a patient threatens grave bodily harm or death to another person, a therapist may be required to inform appropriate legal authorities and the intended victim;

(b) if a patient expresses a serious intent to grievously harm him/herself, it may be necessary for a therapist to reveal information to family members and/or persons authorized to respond to such emergencies in order to protect the patient from harm;

(c) if a court of law issues a legitimate subpoena, a therapist is required to provide information that is specifically described in the subpoena;

(d) if a patient is being evaluated or treated by order of a court of law, the results of that evaluation or treatment ordered must be revealed to the court; and

(e) if a therapist has good reason to suspect that a child or senior citizen is a victim of physical abuse, sexual abuse or neglect, he/she is required to report the abuse or neglect to the Department of Social Services.

I understand these limitations to confidentiality as outlined above.

# CONSENT FOR SERVICES

Page Two

I also understand:

(a) the fee for the above-mentioned services is \$130.00 for the initial session and \$95.00 for subsequent appointments. Appointments last 50 minutes;

(b) the fee for court appearances is \$200.00 an hour and there is a \$95.00 an hour charge for report writing in addition to the usual charges for assessment appointments;

(c) that I must give a 24-hour notice if I wish to cancel an appointment or the full per-session fee may be charged. Information and assistance regarding scheduling of appointments, payment of fees, and insurance coverage for psychiatric services is provided by Ms. Pendergast or Ms. Grantham.

I certify that I understand the contents of this document and I give my consent for psychiatric services.

Patient

Sharon Pendergast, M.S.W. or  
Victoria Grantham, M.S.W.

Guardian for minor child