**Ellen Dudley MA, LCMHC, CRC**
**Licensed Clinical Mental Health Counselor**
**2018 Eastwood Road, Suite 316, Wilmington, NC 28403**
**Telephone (910) 344-0480 Fax (910) 915-8386**

## ATTESTATION FORM

**I have read the Notice Regarding Patient Records Privacy: Policies and Procedures document. My signature below indicates that I agree to its terms. I was given the opportunity to discuss this agreement and ask any questions to clarify information. I understand that I will be provided with a copy of this document upon request.**

______________________________ ______________
**Printed Name** **Date**

______________________________
**Signature**

**My signature below indicates that I do not agree to its terms.**

______________________________
**Signature**

**My signature below indicates that I am not able to sign as I do not understand its terms.**

______________________________
**Signature**

______________________________ ______________
**Witness** **Date**

**I have read the Psychotherapist-Patient Services Agreement document. My signature below indicates that I agree to its terms. I was given the opportunity to discuss this agreement and ask any questions to clarify information. I understand that I will be provided with a copy of this document upon request.**

______________________________ ______________
**Printed Name** **Date**

______________________________
**Signature**

**My signature below indicates that I do not agree to its terms.**

______________________________
**Signature**

**My signature below indicates that I am not able to sign as I do not understand its terms.**

______________________________**Signature**

______________________________ ______________
**Witness** Date