

Lowcountry Psychiatric Associates

Vicki Bonnell, LISW-CP

CONSENT TO TREAT

I, \_\_\_\_\_, give my consent on this  
date of \_\_\_\_\_, for my child/self \_\_\_\_\_  
to receive out-patient psychotherapy with Vicki Bonnell, Licensed Independent Social  
Worker-Clinical Practice.

I have read and signed Ms. Bonnell's Disclosure Statement and Patient Rights.