PROFESSIONAL DISCLOSURE STATEMENT AND
CONSENT FOR TREATMENT WITH DR. CHARLES H. BREWER, JR., PLLC

I acknowledge that I have received and read the *Professional Disclosure Statement and Consent for Treatment with Dr. Charles H. Brewer, Jr., PLLC (version 8/08)* and the *HIPAA Client's Rights (version 8/8)*. I further acknowledge that I seek and consent to treatment with Dr. Brewer. My signature below confirms that I understand and accept all information contained in the *Professional Disclosure Statement and Consent for treatment with Dr. Charles H. Brewer, Jr., PLLC (version 8/08) and the HIPAA Client's Rights (version 8/08).*

Signature of Client: _____ Date: _____

If more than on individual (spouse or family members) is seeking therapy, please have each of the others sign below. Signature below confirms that each understands and accepts all the information contained in *Professional Disclosure Statement and Consent for Treatment with Dr. Charles H. Brewer, jr., PLLC (version 8/08) and the HIPAA Client's Rights (version 8/08).* Additional copies provided upon request.

Signature of Client #2: _____Date: _____

Signature of Client #3: _____Date: _____

Signature of Client #4: _____Date: _____

Signature of Client #5: _____Date: _____

Signature of Client #6: _____Date: _____

Signature of Client #7: _____Date: _____

Revised 11/09