# **PROFESSIONAL DISCLOSURE STATEMENT &**

**INFORMED CONSENT**

The following information regarding Braveheart Counseling, LLC. services and business policies has been provided for your protection and to assist you in making an informed choice about your treatment. This document contains important information about professional services and business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. Please review carefully and initial next to each heading as you read/agree to it.

**About Your Counselor**:

Michelle Adams is a Licensed Clinical Social Worker. I am licensed to practice in the state of Georgia and in South Carolina. She is a graduate of Florida State University with a Masters of Social Worker. Her undergrad degree is a B.S. in Communication for the University of North Florida. She has 10 years of direct clinical experience. Additionally, she has served as a program supervisor for the Nevisar Star Parenting Program, field instructor for LMSW Interns at a variety of colleges for the last 8 years, and has completed the NASWGA Clinical Supervisor course. She trained directly with Dr. Stephen J. Bavolek where she was taught the Nurturing Parenting Program. The NPP is an evidence-based parenting program developed in 1979. It has been researched to be a validated and reliable inventory used to assess parenting attitudes directly related to child abuse and neglect. M. Adams was named an expert witness in Circuit 4 dependency court under the former Judge David Gooding, regarding an individual’s parenting skills and ability to care for their children. After relocating to Augusta, Georgia she worked at the Augusta State Medical Prison with Dr. Reddy on the Crisis Stabilization Unit for approximately three years. While on the CSU it was her responsibility to diagnose and treat critically ill mental health patients and deescalate others who were attempting suicide or self-injurious behaviors. After obtaining her LISW- CP in South Carolina, she opened her private practice in 2021. In 2024 she expanded services to include Parenting services and Social Work services.

Ms. Adams has experience in offering parenting and clinical assessments, individual and family psychotherapy sessions, group psychoeducational classes, and supervised visitation sessions. Her specialized certifications include Telehealth, Trauma Focused Cognitive Behavioral Therapy, and Nurturing Parenting Program Facilitator.

Services are offered both remotely via telehealth services and in-person at: 3524 Jefferson Davis Hwy, Graniteville, SC 29829 in the Hope Community Counseling Center (HCCC). HCCC is not a group practice. Each provider working at HCCC is an independent provider. A second office location is available at 3114 Augusta Tech Drive, Suite 203, Augusta, GA 30906. Both offices can be reached by phone or text at 706-250-1442 or by emailing madams@braveheart-counseling.com.

Braveheart Counseling is committed to providing the highest quality of care. As part of our ongoing efforts to improve our services, we occasionally have social work interns observe counseling sessions. These interns are closely supervised by Michelle Adams, Licensed Clinical Social Worker (LCSW) as part of their educational training.

**Communicating With Your Counselor**: Clients may call Braveheart Counseling at (706) 250-1442. Your counselor may not be able to answer your call. Your specific counselor may provide an alternate mobile number to call/text. If your counselor does not answer, you will be able to leave a message on the voicemail system. Your counselor will make every effort to return calls within 24 hours, with the exception of weekends, holidays, and/or emergency situations. Clients need to provide a name, telephone number where they can be reached, and be aware that the counselor will be identifying herself when returning the call. Be aware that caller ID on the client’s telephone may identify the counselor as the caller and they have no control or liability for such occurrence. Any messages left on weekends or holidays will be returned the next business day if possible. You can contact your counselor at madams@braveheart-counseling.com  Be aware that email and text messages are not a secure form of communication. Your counselor cannot protect against the possibility that the information sent over email or text could be intercepted by unwanted parties. Please refrain from disclosing any sensitive or personal information over email or text. It is recommended you never use your employer’s emails service for your personal emails. While electronic communication can not be 100% secure, Braveheart Counseling, LLC., uses all precautions to ensure your privacy is protected by using specialized programs specific to this field that has extra securities surrounding both phone messages, text messages and emails.

If you have an EMERGENCY, every attempt will be made to return your call in a timely manner, however it remains your responsibility to take care of yourself. If you are unable to take care of yourself or keep yourself safe, then call 911 or go to your local emergency room.

By reading and signing this Agreement you acknowledge that you have been informed:

\_\_\_\_\_ Cellular/Electronic Communications: Braveheart Counseling cannot guarantee the confidentiality of conversations conducted on cellular/mobile telephones and/or text messaging and/or email correspondence. I accept the risk of disclosure of personal information and understand this method of communication may be used.

\_\_\_\_\_ Cellular/Electronic Communications: I give Braveheart Counseling permission to contact me by these methods of communication.

\_\_\_\_\_ Non-Emergency Business: I also acknowledge that Braveheart Counseling and my counselor are not a 24-hour emergency service. Office hours are by appointment on weekdays. In the event of an emergency, you must call 911 or go to local emergency room.

**Types and Purpose of Services:**

Braveheart Counseling embraces a strengths-based perspective and borrow from many different theory bases for psychotherapy in aiming to understand and meet the individual needs of each person and of each family. These theories include cognitive-behavioral, solution-focused, reality-based, mindfulness-based and family systems theories. Techniques that are utilize may include dialogue, psycho education, relaxation, reframing of negative thoughts, positive decision-making, role-play, mindfulness or writing/art exercises. We will work together to establish realistic and attainable goals for you to achieve. These goals are flexible and we may modify them throughout the therapy process as your needs change.

Active participation in and out of session is essential to your success. We will often assign tasks between appointments to help strengthen the skills you acquire during therapy and empower you to resolve issues after the therapeutic relationship has ended.

Length of therapy, an estimate for termination can be discussed during our sessions but it is just an estimate. Therapy is a unique process for each individual and duration and success of treatment will vary according to acuity of presenting issues. In saying that, you have the right to terminate therapy at any time. We ask that if you decide to discontinue therapy that you discuss this with your counselor before doing so. Communication is essential to a healthy working relationship. The therapeutic environment should be one that is safe, honest, and respectful. Although we will be discussing personal and psychologically intimate information, our relationship must always remain professional.

Counseling is a growth process that moves through various stages. The first 2-3 sessions will involve a comprehensive evaluation, clarification of specific goals and development of a treatment plan. During the evaluation, it is important to discuss things openly and honestly. You should evaluate this information and make your own assessment about whether you feel comfortable continuing with your therapist. Goals may be reached through referrals to outside professionals who specialize in that particular service. Treatment will conclude when your goals are reached. This should be determined through an open, honest agreement among all individuals involved, including your counselor except in the event you determine to discontinue counseling. If you have questions about treatment or procedures, you should discuss them whenever they arise. If doubts persist, your therapist can assist with contacting another mental health professional for a second opinion.

**Counseling Risks**:

Seeking new solutions, exploring unpleasant events, and making changes can lead to discomfort and uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness. Attempting to resolve issues that brought you to therapy in the first place, such as with relationships may result in changes that were not originally intended. Participating in therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. There is no guarantee that counseling will yield positive or intended results. Using mental health insurance may be detrimental to you in obtaining future health, disability or life insurance policies. However, therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, increased skills for managing stress and resolutions to specific problems. Psychotherapy requires your active involvement, honesty and openness. It is important to your counselor that each client is served well and appropriately. If your counselor does not feel they have the expertise needed in the client’s specific area of concern and it appears that another counselor or mental health professional would serve the client better in terms of meeting her/his treatment goals, then the client will be provided with the appropriate referrals.

**CLIENT RIGHTS AND THERAPIST DUTIES**

**Patient's Rights:**

* ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
* ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
* ***Right to Request Restrictions*** *–* You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
* ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** *–* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
* ***Right to Inspect and Copy*** *–* You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $0.50 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
* ***Right to Amend*** *–* If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
* ***Right to a Copy of This Notice*** *–* If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
* ***Right to an Accounting*** *–* You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
* ***Right to Choose Someone to Act for You*** *–* If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
* ***Right to Choose*** *–* You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
* ***Right to Terminate*** *–* You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.
* ***Right to Release Information with Written Consent*** *–* With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

**Therapist’s Duties:** Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI. They reserve the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, they are required to abide by the terms currently in effect. If the policies are revised, you will be provided with a revised notice in office during your session.

**COMPLAINTS**: It is important that all work with clients is in an effective and efficient manner. It is also of utmost importance that clients feel they are treated ethically and fairly throughout the counseling relationship. Therefore, if at any time clients are dissatisfied with any aspect of the clinical process, please inform your counselor immediately. If you are concerned that your privacy rights have been violated or you disagree with a decision made about access to your records, you may contact your counselor, the South Carolina Department of Labor, Licensing and Regulation, 110 Centerview Drive, Columbia, SC 29210 or (803) 896-4658, or the Secretary of the U.S. Department of Health and Human Services.

**HIPAA NOTICE OF PRIVACY PRACTICES, CLIENT RIGHTS & THERAPIST DUTIES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes policies related to the use and disclosure of the client’s healthcare information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations (to include evaluating the quality of care that you receive) are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that you are provided with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA and its application to your PHI in greater detail.

The law requires that your counselor obtain your signature acknowledging that they have provided you with this. If you have any questions, it is your right and obligation to ask so they can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless your counselor has taken action in reliance on it.

**Use and Disclosure of Protected Health Information:**

* ***For Treatment* –** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
* ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
* ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

**Confidentiality**:

Except for specific legal circumstances described below, you have the absolute right to the confidentiality of your therapy. Your counselor will not disclose to anyone what you discuss in session, or that you are even in counseling, without your written permission. The following are legal exceptions to your right to confidentiality. You will be informed of any time your counselor has to put these into effect.

 1) If you threaten grave bodily harm to yourself or another or death to another person, your counselor is required by law to inform the intended victim and/or appropriate law enforcement agencies; or,

 2) If a subpoena is served, your counselor may be required by law to provide information specifically described in the subpoena; or,

 3) If you reveal information relative to current child or vulnerable adult abuse or neglect, I am required by law to report this to the appropriate authority; or,

 4) If you are in counseling or being tested by order of the court of law, the results of the treatment or tests ordered may be revealed to the court.

Due to the expectation of confidentiality for all clients at the Hope Community Counseling Center, video or any other method of recording is strictly prohibited, unless written consent is provided by *all* parties present. This pertains to all recording devices, including but not limited to: computers, cell phones, tablets, smart watches, smart glasses, and others. These devices are not allowed in the therapy room without permission from your counselor.

**LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communication between a patient and a therapist. In most situations, they can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where they are permitted or required to disclose information without either your consent or authorization. If such a situation arises, your counselor will limit their disclosure to what is necessary. Reasons they may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which your counselor is legally obligated to take actions, which they believe are necessary to attempt to protect others from harm, and they may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the South Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the South Carolina Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

# **Client Records**: Federal and state laws and professional ethical guidelines require that mental health professionals keep Protected Health Information (PHI) about you in your clinical record. Except in unusual circumstances that involve danger to yourself and others or makes reference to another person (unless such other person is a health care provider) and your counselor believes that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to your counselor confidentially by others, you may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or confusing to untrained readers. For this reason, it is recommended that you initially review them in your counselor’s presence, or have them forwarded to another mental health professional so you can discuss the contents. If the counselor refuses your request for access to your records, you have a right of review (except for information provided to your counselor confidentially by others) that will be discussed with you upon request.

If you are attending therapy for Couples therapy, please note Braveheart Counseling will keep one confidential record that documents the work as a couple (dates of sessions, progress notes, etc.). The contents of this medical record may not be released to any person without the written consent of both the undersigned clients, except as required or permitted by law.

All treatment records are the property of Braveheart Counseling and are governed by the laws of confidentiality of Georgia and professional association guidelines. Documentation is kept in a locked file cabinet within the office and on an electronic health care record. I may use and/or share your health information for treatment, to obtain payment for treatment, for administrative purposes to evaluate the quality of care that you receive and for all other purposes described in this notice.

If client is a minor, under the age of 18, please complete the Minor’s Informed Consent Form.

**FEES, BILLING, AND PAYMENT**:

Intake sessions may be up to 90 minutes and counseling sessions are typically 55 minutes and billed at standard fee available by request or at the contracted insurance rate. Session fees or insurance co-payments are payable at time of service unless the client provides at least 24 hours advance notice of cancellation or unless alternative arrangements have been made. Insurance companies do not provide reimbursement for cancelled or missed sessions. Therefore, the client will be required to pay a fee for missed appointments (unless the client and counselor both agree that the client was unable to attend due to circumstances beyond her or his control).

Each client is seen by appointment only. If a client arrives late, the appointment must end as scheduled and the client will be charged for the full amount of the scheduled time. This allows each client thereafter to be seen as scheduled. Your signature on this disclosure statement indicates that you have read and understand the fees and cancellation policy. Fees will be reevaluated periodically. See FEE AGREEMENT FORM for specific fees.

While your counselor may be an in-network provider for several major insurance companies, it is the responsibility of the client to contact the client’s insurance provider directly to be informed of specific coverage for mental health services provided in an office by a licensed mental health counselor. Your counselor will file insurance claims with the written permission of the client as a service to the client. However, you will be responsible for paying the entire fee if your insurance fails to authorize units of service or if no units of service are available to you. Should a balance accrue and no payment is received, your counselor reserves the right to seek remuneration by any means legally possible including, but not limited to, the retention of a collection agency.

Each client is expected to pay for each session at the time it is held. Payments are preferred by credit card, but payment is accepted for cash and check, if necessary. If the insurance is billed per client’s instructions and does not pay the expected amount the client will be mailed an invoice to pay the remaining balance within 30 days. Should a check be returned for insufficient funds, there will be a $25 fee in addition to the amount for which the check was written.

In addition to counseling sessions, charges will be incurred for other professional series clients may need, and a pro-rate will be calculated if the work is for periods of less than one (1) hour. Other series include telephone conversations lasting longer than ten (10) minutes, consulting with other professionals with the client’s permission, preparation of records or treatment summaries, or any other service that the client may request.

**INSURANCE**: You need to be aware that client contracts with insurance companies require that information may be shared relevant to the services that are provided. Your counselor is required to provide a clinical diagnosis. Sometimes they may be asked to provide additional clinical information such as a treatment plan or summaries or copies, of the clients’ entire clinical records. In such situations, your counselor will make every effort to release only the minimum information about you, the client, that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, the counselors have no control over what they do with the information once they have it. By signing this Professional Disclosure Statement, the client agrees to pay for counseling services (i.e. their co-pay and any other costs incurred or not covered by their insurance company) at the time of each session. The client acknowledges an understanding of the limits of confidentiality given the involvement of their insurance company in the payment of their mental health care and services.

**CLIENT INFORMATION**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Text reminders? \_\_\_\_\_ Yes\_\_\_\_\_ No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consent to receive information about additional services? \_\_\_\_\_\_\_ Yes \_\_\_\_\_\_ No

**CONSENT TO Braveheart Counseling Services including PSYCHOTHERAPY**

By signing this form:

* I acknowledge that I have received and read the above in its entirety.
* I am informed about the policy regarding confidentiality of information I may disclose during counseling and the limits of that confidentiality.
* I understand that no promises have been made to me as to the results of treatment provided by this therapist.
* I am aware that I may stop treatment with this therapist at any time.
* I understand that I will be charged based on the amount of time with my counselor and that I am responsible for payment at the time services are rendered. I understand that if payment for services is not made, the therapist may stop my treatment and my bill will be sent to a collection agency.
* I know that I must give 24 hours’ notice before canceling or rescheduling appointments to avoid being charged.
* I understand that whatever I discuss in treatment will be kept confidential except for the conditions listed in the records and confidentially section.
* I am aware that information about my treatment may be shared with my insurance agency or other third-party payer, and I authorize the release of any medical or other information necessary to process a claim. With agreement and full understanding and of these provisions, I give my consent to receive counseling services.
* I acknowledge that there are additional forms required prior to receiving treatment including information pertaining to minors, fee agreement form and specific consents for specialized services.

Client Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Parent/Guardian (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Counselor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_