

 **Live Life Counseling, LLC**

 1435 Haw Creek Circle, Suite 403, Cumming, GA 30041

 https://livelife-counseling.com

**ASSESSMENT INFORMED CONSENT**

**When families have involvement with the Department of Family and Children Services, comprehensive assessments are completed to assess the family’s strengths and needs. These assessments are completed at the request of the Department of Family and Children's Services. The results will be provided to your Department of Family and Children's Services Caseworker. Confidentiality is limited. Any statements, impressions, information or observations gathered during this assessment may be made available to the interested parties such as the Department of Family and Children's Services Caseworker, Multi-disciplinary Team Members, CASA, and/or the Court. The goal of this assessment is to determine your family's strengths and needs and to provide recommendations for treatment planning purposes.**

***I have read the above statement or had it read to me and understand the goals of the assessments requested of me. I understand the limits of confidentiality my family and I will have with staff of Live Life Counseling for this purpose.***

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Signature and Date**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Signature and Date**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Signature and Date**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Print Signature and Date**