



## TREATMENT/FINANCIAL AGREEMENT

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

### PERMISSION FOR TREATMENT

1. I agree to permit PROVIDER to provide services to me and/or my minor dependents.
2. I understand that PROVIDER can make no guarantees about the outcome of my treatment but I can expect to receive services, which are ethical and professional.
3. I understand PROVIDER agrees to comply with all privacy laws and respects my right to confidentiality. As a client, I agree to attempt to be honest and disclose information to assist PROVIDER in providing appropriate services.

### FINANCIAL AGREEMENT

1. I understand that services are provided on a fee for service basis and that payments are due at the end of each session. Sessions are 50 minutes.
2. If I fail to keep an appointment without notifying provider **24 hours in advance**, I realize that I will be charged a \$100.00 fee.
3. I understand that there will be a \$20.00 handling fee for all returned checks.

I understand that I am financially responsible for charges not covered by this authorization.

\_\_\_\_\_  
CLIENT/GUARDIAN'S SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE