

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 45 minutes.

Intake sessions	\$150.00
Individual & family session	\$110.00
2. If I fail to keep an appointment without notifying provider **24 hours in advance**, I realize that I will be charged a \$110.00 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 for services provided.

CLIENT / GUARDIAN'S SIGNATURE DATE

WITNESS DATE