

**AGREEMENT FOR PSYCHOTHERAPY SERVICES
CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY**

I hereby authorize and request that GAIL GABRIEL, MFT, conduct the assessments, treatment, referrals and procedures necessary for the course of my care (or of my child's) as a patient. I have received and read the above Office Policy and Informed Consent Memo and agree to it. I understand that I have the right to have any procedure fully explained to me and I may discontinue treatment at any time if I so desire. I agree that I will be held financially responsible for each session. I agree that I will be financially responsible for any missed appointments without 48 hours notice of cancellation. I understand that all information disclosed within sessions is confidential and may not be revealed without my prior written consent, except where disclosure is required or permitted by law. I agree to and understand the risks to my confidentiality when using mail, email, voice mail, and telephone communication. In cases where I cannot be reached or there is concern for my safety or danger to others, I name _____ as my emergency contact @ _____.

I have read, understood and received a copy of the HIPAA Notice of Privacy Practices. I have read, understood, received a copy of and agree to the above Office Policies and Informed Consent Memo. I have read, understood, and agree to this Agreement for Psychotherapy Services and consent to treatment and financial responsibility for these services.

Signature of Patient or Legal Representative

Date

Signature of Patient or Legal Representative

Date

Signature of Clinician

Date