GAIL GABRIEL, MS
MARRIAGE AND FAMILY THERAPIST
CALIFORNIA LICENSE: LMFT31655

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 Office Policies 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 24 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.

EMERGENCY CONTACT: Please name the person(s) Gail may contact in an emergency, both to provide for your safety and to give you information when you cannot be reached. Please specify how to reach them most efficiently.

NAME: _____ TELEPHONE: _____

NAME: _____ TELEPHONE: _____

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 Office Policies 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**

555 PETERS AVENUE, SUITE 230, PLEASANTON, CALIFORNIA 94566
TELEPHONE: 925 - 997-1799