1032 Turnpike Street
Suite 204
Canton, MA 02021

Renz Counseling

378 Page Street
Suite 6
Stoughton, MA 02072

THERAPIST-PATIENT SERVICES AGREEMENT

SIGNATURE PAGE

Please initial each of the following policies to indicate that you have read, understand, and agree to them as they are fully stated on the previous pages. Please sign your full name at the bottom of this page to indicate that you have read, understand, and accept the terms of this Therapist-Client Services Agreement. Please keep the preceding pages of the Agreement for your records.

Initial Below:

_____ I have read, understand and agree to the policies regarding **Limits on Confidentiality.**

_____ I have read, understand and agree to the policies regarding **Professional Records** and **Patient Rights.**

_____ I have read, understand and agree to the policies regarding **Minors and Parents**.

_____ I have read, understand and agree to the policies regarding **Professional Fees / Financial Agreement.** I agree to the **$85 late cancellation / no show fee.**

_____ I have read, understand and agree to the policies regarding **Credit/debit card payments.** I have provided my credit/debit card information (required) and agree to have it charged accordingly.

_____ I have read, understand and agree to the policies regarding **Insurance Reimbursement.**

_____ I have read, understand and agree to the policies regarding **Contact & Emergency Information**.

_____ I have received a copy of the Renz Counseling, LLC **Notice of Privacy Practices.**

I have read and understand the above statements on this page and the preceding pages of the Therapist-Client Services Agreement, and I consent to receiving services based on the terms stated. I have received a copy of all policies for future reference.

_____
Client / Insured Name ***(please print clearly)***

_____ _____
Client / Insured ***Signature*** Date

_____ _____
Clinician's signature Date