INFORMED CONSENT CONTRACT

Family Address: ______________________________________ Date: ________________________________

____ Home Phone: _________________________

How did you hear about New Beginnings? ____

All family members living at your address *(including yourself)*:

Name	Family Relationship	Age or DOB	Work Phone	Cell Phone
	self			

Sign your initials below to signify your agreement with the following two statements.

_______ I have received and read the Client Information & Policies Sheet for New Beginnings Therapy Services.

_______ I understand the financial policies of New Beginnings Therapy Services, Inc. and agree to pay $85 for each session. This fee is payable at the time service is rendered. I am fully responsible for the fee, unless other arrangements have been made. Therapy services provided by phone are billed at the same rate as our face-to-face sessions. If I fail to attend a scheduled session without *24 hours notice* I remain financially responsible for that missed session; the exception to this standard is when I am unforeseeably and/or unavoidably prevented from attending by accident, illness or inclement weather.

Person responsible for payment: _________________________________ Phone: ________________________
(if not listed above)

Email address (for person responsible for payment): ____

Signature of everyone consenting to participate in therapy:

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Therapist(s) Signature:

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*Date:*_________________________________