



CLIENT AGREEMENT/INFORMED CONSENT
ID # _____

- I _____ (printed name) agree to attend my (my child's) sessions regularly. I agree to call **at least 24 hours in advance** when I am unable to attend. I understand that I am responsible for payment of any missed sessions if I do not provide a 24 hour notice of cancellation.
- I agree to be on time for each session. If I am being transported by a secondary party, I agree to communicate the importance of being dropped off and picked up at the appropriate times.
- I agree to pay \$_____ for each individual/family session **at the time of service**. If I am utilizing insurance, I understand that Angel House Bereavement Center will not bill my insurance directly, but will provide me with a receipt for payment and a letter documenting initiation of services should I choose to seek reimbursement from my insurance provider.
- I understand that children cannot be left unattended in the waiting area and agree to provide appropriate supervision.
- I understand that Angel House Bereavement Center's staff are only available during regular business hours and that Angel House Bereavement Center does NOT provide 24 hour emergency phone service. Crisis assistance can be obtained by going to the nearest emergency room or calling 911.
- I understand that counseling alone may not resolve my problem or concern. While the staff at Angel House Bereavement Center will do their best to help me, they may at times, with my consent, consult with other medical and/or mental health professionals to seek the best approach to care. They may also provide referrals for concurrent care.
- I understand that Angel House Bereavement Center is dedicated to furthering the education of mental health professionals in our community and may, as a result, have master's level student social work or counseling interns providing services under the supervision of a Licensed Clinical Social Worker or Licensed Mental Health Counselor. Said students will identify themselves clearly, both verbally and in writing.
- I understand that Angel House Bereavement Center is a nonprofit organization that depends on donations to provide therapy services at reduced fees. I agree that any credits remaining on my account 3 months after conclusion of services will be considered a donation unless I request in writing that the credit be returned to me.
- **I have read, understand and agree to the above statements. My signature indicates that I give full and informed consent to receive services for myself and/or for my minor children.**

Parent/Guardian Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

Child/Adolescent Signature _____ **Date** _____

Witness Signature _____ **Date** _____