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CLIENT-THERAPIST SERVICE AGREEMENT

This must be signed prior to your first session

1. I have received a copy of the **Anne Storelli, LPC, LMFT Disclosure Statement** and a copy of the **Anne Storelli, LPC, LMFT Privacy Notice**.

_____ _____
Client name (Please print) Date

_____ _____
Responsible person (Please print) Relationship to client

2. I have read, understood, and accept the following by initialing each item:

   _____ that by seeking reimbursement for therapy services from my insurance provider will involve disclosing Protected Health Information, including a diagnosis.

   _____ that Anne Storelli, LPC, LMFT may use Protected Health Information within the practice for the purpose of Treatment/Consultation.

   _____that my appointment time has been reserved for me, and I am required to give 48 hours notice if I need to change or cancel my appointment time. I understand that I will be charged a $50 fee for “no show” or late cancellation with the exception of illness or emergencies.

   _____ that I have read the **Disclosure Statement** and have had the opportunity to ask any questions.

I have read, understood, and accept all of the provisions of the Anne Storelli, LPC, LMFT Disclosure Statement and Anne Storelli, LPC, LMFT Privacy Notice and hereby consent to counseling in full accordance of these terms.

_____ _____
Name (Responsible Person) Date

_____
Signature