Client Agreement

PLEASE READ THE FOLLOWING CAREFULLY
AND INITIAL AFTER EACH STATEMENT

- I understand that I am responsible for the fee payment at the beginning of each appointment. ___
- I agree to be responsible for the full payment of the fees for services rendered regardless of whether insurance reimbursement will be sought. ___
- Cenla Professional Counseling will honor contractual agreements made with those managed healthcare companies which stipulate reimbursement restrictions. ___
- I hereby consent to treatment by Suzanne Palmer, LPC, LAC, NCC, MA although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions. ___
- I understand that I have the right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop. ___
- I hereby authorize the release of necessary medical information for insurance reimbursement purposes. ___
- I authorize the payment of medical benefits to the provider of services.

X_____

Signature of client or parent if client is a minor *Date*

Cenla Professional Counseling, LLC.
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