

## 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 Theresa Cole, LCSW 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.  
4207 Parliament Drive, Suite B  
Alexandria, LA 71303