Denise M. Carr, MS, LMFT
Licensed Marriage and Family Therapist
540 Pennsylvania Avenue, Suite 325
Fort Washington, PA 19034
215-601-6271

AGREEMENT FOR THERAPY SERVICES
Consent for Treatment and Financial Responsibility

I hereby authorize and request Denise Carr, M.S., LMFT, conduct the assessments, treatment, referrals and procedures necessary for the course of my care as a client. I have received and read the Office Policies document and agree to it. I understand that I have the right to have any procedure fully explained to me and I may discontinue treatment at any time if I so desire. I agree that I will be held financially responsible for each session. I agree that I will be financially responsible for any missed appointments without 24 hours notice of cancellation. I understand that all information disclosed within session is confidential and may not be revealed without my prior written consent, except where disclosure is required or permitted by law. I agree to and understand the risks to my confidentiality when using mail, email, telephone, voicemail, text message communication and electronic payment.

EMERGENCY CONTACT: Please name the person(s) Denise Carr may contact in an emergency, both to provide for your safety and to give you information when you cannot be reached. Please specify how to reach them most efficiently.
NAME: ______________________________________ Phone No.: ____________________
NAME: ______________________________________ Phone No.: ____________________

I have read, understood and received a copy of the HIPAA Notice of Privacy Practices. I have read, understood, and agree to the Office Policies document. I have read, understood, and agree to this Agreement for Therapy Services and consent to treatment and financial responsibility for these services.

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Signature of Client or Legal Representative Date

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Signature of Client or Legal Representative Date

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Signature of Clinician Date