Sharon Thompson LLC
Sharon L. Thompson, MA, LMFT
Marriage and Family Therapist
License # 35001761A

Agreement for Services and Payment

Consent to Treat

I give my consent for treatment for myself, and/or my legal dependent(s), _____ _____, with Sharon Thompson. I understand that I may be referred to someone with a required expertise if necessary. Ms. Thompson will provide only services for which she has been trained, licensed, or certified. I also acknowledge that no guarantees have been made to me or relied upon by me. Because psychotherapy is a cooperative effort between me and my therapist, I must work with Ms. Thompson in a cooperative manner to resolve my difficulties. I understand that during the course of my treatment, material will be discussed which may be upsetting in nature and this may be necessary to help me resolve my problems.

Services and Fees

Individual, Couple, or Family Psychotherapy	55 minutes	$150
	85 minutes	$225

Financial Responsibility

I understand that payment is due at the time of service. I may pay with cash, check or credit card. In signing this statement, I agree to pay the established fee. *I agree that because my appointment time is reserved for me, **I will be charged the full, regular fee for any session missed without 24 hours' notice***. I also understand that any fees associated with a returned check will be my responsibility within seven days of notification. _____ (Initial here)

Confidentiality

All of my communication with Sharon Thompson is confidential. Ms. Thompson regards the information I share with her with the greatest respect. A signed release of information will be required for information to be released to others or for Ms. Thompson to acquire information from others. The only exceptions to this would be situations where 1) I have become dangerous to myself or others, 2) in cases where child or elder abuse is suspected or 3) instances where the court or government subpoena records. *In these situations, providers are required by law to share information needed to prevent harm to myself and/or others or to comply with a court order.* I also consent to the counselor's use of consultation with appropriate professionals who are bound by the same rules of confidentiality with the stipulation that every effort will be made to keep my identity anonymous.

Signature: A _____ Date _____

B _____ Date _____

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Cancellation Policy:

As stated on the contract for services, the cancellation policy is:

> *I agree that because my appointment time is reserved for me,* ***I will be charged the full, regular fee for any session missed without 24 hours' notice****.*

I need time to contact others who may have been previously told there were no available appointment times. Please call or email your cancellation. Any cancellation or no-show under 24 hours will be required to pay for the scheduled appointment. Please enter your payment information below to secure your scheduled appointments. Your card will not be charged unless a cancellation occurs under 24 hours.

Circle: Visa MasterCard Discover Amex

Name on Card _____

Card Number _____

Exp _____ / _____ CVV _____ Billing Zip: _____

Signature authorizing cancellation charge _____

Today's date _____