AGREEMENT FOR THERAPY

______ I agree to receive therapeutic services provided by Pat Ahl, LPCC, NCC.

______ I have read, understood, and signed the informed consent related to therapy and I understand the risks and benefits of receiving these services and the risk and benefits of not receiving these services.

______ I acknowledge that I have received and understand the Notice of Privacy Practices for this office including HIPPA.

____

Client Signature Date

HEALTH PROVIDER'S STATEMENT

I have inquired to ensure that the Client understands the above description of the limits on confidentiality.

____

Clinician Signature Date

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