Paloma SparrowHawk, LMHC
Psychotherapeutic Services

AGREEMENT TO ACCEPT SERVICES AND FINANCIAL RESPONSIBILITY STATEMENT

I, _____, do hereby authorize Paloma SparrowHawk, LMHC, to administer mental health/psychotherapeutic services to _____

I understand that the information disclosed to Paloma SparrowHawk, LMHC, is protected by Federal/State Law unless otherwise provided for in the regulations. I hereby certify that I have fully read and understood the above authorization to accept mental health services.

By signing below I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that it is my right to terminate services if I am dissatisfied with the services received. I also understand that Paloma SparrowHawk, LMHC, has the right to terminate services if payment for services rendered is not received.

I authorize Paloma SparrowHawk, LMHC, to receive payment of my medical benefits by my insurance company and to release information necessary to said insurance company. I hereby give consent for the use and disclosure of personal health information to provide treatment, to arrange payment for services, and/or for other health care operations as provided by law. I understand that I have a responsibility to inform Paloma SparrowHawk, LMHC of any change of financial status which would affect this Agreement.

I acknowledge my responsibility for any deductibles, co-payment amounts required by my insurer. If I have no insurance or if my benefits are exhausted, I understand and agree to pay for services not covered by insurance. I agree to keep Paloma SparrowHawk, LMHC, apprised of any change in address.

_____ Date: _____

Client Signature