life united™
Empowering Life's Relationships℠

101 Timberlachen Circle
Suite 201
Lake Mary, FL 32746

Client Agreement, Indemnity, and Consent Form

I/We, _____, have applied for counseling services at Life United, LLC. for myself/ourselves and the following persons for whom I/we am a legal guardian: _____

_____.

I/We understand that a counseling session is normally fifty minutes in length, and that payment is to be made each session. I/We understand that the cost for each fifty minute session is **$**_____ (notwithstanding special pricing, bundled rates, groups, or family sessions). I/We understand that a 24 hour cancellation notice is required if I/we am not able to attend the originally scheduled appointment, with the exception of emergencies, and if not done, a session fee may be charged. There is a $50 fee assessed in addition to the session fee for any returned checks.

I/We understand that therapist-client confidentiality is always maintained with the exception of suicidal threats, homicidal threats, and any child abuse by an adult to a child (past or present).

I/We give permission to the therapist to seek clinical supervision or consultation about my/our situation when necessary. I/we give Life United, LLC. permission to contact me/us at home via phone, mail, and e-mail.

I/We agree to indemnify and hold harmless Life United, LLC. , its agents and employees, from any claims, actions, damages, or suits arising from or relating to any counseling, instruction, or advice rendered during services provided.

I/We understand that therapy can be a lengthy process. It normally takes a minimum of six sessions to begin making significant progress on presenting issues. Therapy works best if the client(s) can commit to at least six sessions.

I/We have read the above information carefully, understand its contents, and agree to receive services for myself and/or any child under the age of 13 under these conditions.

Client Signatures: (13 years or older)

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Therapist(s) Signature: _____ Date _____

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