

Carrie Haynes Sharp, MEd, LPC
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AGREEMENT/INFORMED CONSENT

I hereby consent to enter treatment with Carrie Haynes Sharp, MEd, LPC. I understand that therapy is a joint effort between the clinician and client, the results of which cannot be guaranteed. Progress depends on many factors including motivation, effort, and other life circumstances. I agree that I will be responsible for the payment of all professional fees. I know that I can end my relationship with my clinician at any time I wish and that I can refuse any requests or suggestions made by my clinician.

By signing below, I am indicating that I read, understand, and agree to the information contained in the Office Policies or Group Participation Agreement document, and I have received and reviewed a copy of this office's "Notice of Policies and Practices to Protect the Privacy of Your Health Information."

I acknowledge that I have received the information listed above from my clinician. I also understand that it is very important that I read this information carefully before our next session. I understand that I can discuss any questions I have about the procedures at that time.

Client or parent signature

Date

Client or parent printed name

Therapist signature

Date

INSURANCE AUTHORIZATION/RELEASE OF INFORMATION

(Signature necessary only if using insurance to pay for services)

By signing below, I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of insurance benefits to the party who accepts assignment..

Client signature

Date