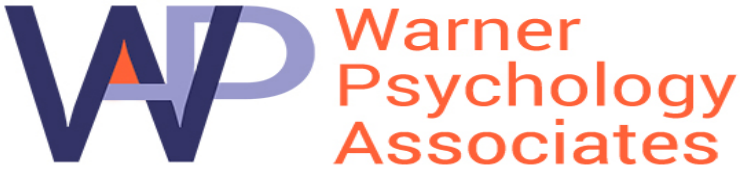

General Information and Psychological Services Agreement

Welcome to Warner & Associates, LLC, a psychological services practice, owned by Beth S. Warner, Ph.D., that provides psychotherapy and psychological evaluations. We appreciate your trust and the opportunity to assist you. Maryland law requires that we provide you with this information, and that we obtain your signature acknowledging that we have done so. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections, and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Policies and Practices to Protect the Privacy of Patient Health Information (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. This Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. Please read carefully and jot down any questions you might have so that we can discuss them at your next meeting. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding to us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you or your child will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves addressing unpleasant aspects of one's life, you or your child may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what will be experienced.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer some first impressions of what our work will include, and treatment directions, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 45-minute session per week at an agreed upon time, although meetings may be more or less frequent. In the initial stages of therapy, we generally require weekly meetings until a satisfactory working relationship has been established.

SCHEDULING AND CANCELLATION/MISSED APPOINTMENT POLICY

Scheduling presents a special problem in private practice, because once a given hour is blocked out, it typically cannot be filled again on short notice. **It is office policy to bill $80 for missed sessions that are cancelled with less than 24-hours notice, unless there is an emergency or circumstance beyond your control (e.g., sudden acute illness, family crisis, severe weather).** It is important to note that insurance companies do not provide reimbursement for cancelled or missed sessions.

It is our policy to address multiple missed sessions in therapy. However, if 3 sessions are missed in a row, and not for reasons involving an emergency, your file will be closed and a termination letter mailed to you. *Please be aware that fees for missed visits are not covered by insurance.* Excessive lateness (e.g., 20 minutes late for a 50 minute session) may also result in a prorated charge, as insurance cannot be billed for a full session in such an event.

In the event that your mental health provider cannot come into the office due to severe weather, they will try to inform you directly if possible. However, we will change the voicemail message to indicate that the office is closed. If you have an appointment on a day in which the weather is questionable, please call the office before coming to your appointment.

When your provider is scheduled to take a vacation, they will let you know in advance. When your provider is absent, if needed, another provider will be available for back-up emergency coverage. Information about coverage will be left on the office voicemail. In the rare event that your provider is unexpectedly away or ill, coverage information will be left on the office voicemail.

PROFESSIONAL FEES

The initial evaluation session fee is $160. Subsequent sessions are $140 for a 45 minute session. Other professional services you may require such as report writing, telephone conversations that last longer than 10 minutes, attendance at meetings or consultations with other professionals that you have authorized, preparation of records or treatment summaries, or the time required to perform any other service, will be billed on a prorated basis of the individual therapy fees.

If you become involved in legal proceedings that require your therapist's participation, you will be

expected to pay for all of their professional time, including preparation and transportation costs, even if the services are requested by another party involved in your legal matter. Because of the difficulty of legal involvement, we charge $450 per hour for preparation and attendance at any legal proceeding.

CONTACTING US

Due to mental health providers' schedules, we are often not immediately available by telephone. Providers will not answer the phone when with a client. When we are unavailable, the office telephone is answered by voicemail that is monitored frequently. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please provide times when you will be available, as well as your phone number. If you are unable to reach your provider and feel that you cannot wait for a return r call, contact your family physician or call, or go to the nearest emergency room and ask for the psychiatrist or psychologist on call. If your provider will be unavailable for an extended time, your provider will provide you with the name of a colleague to contact, if necessary.

USE OF ELECTRONIC COMMUNICATION (email and text)

Electronic communication is highly efficient in communicating with clients. However, email and text messages are not a secure or confidential means of communicating. Because of security reasons, we use email only for issues that are not sensitive, such as scheduling, sending information relevant to operations within the practice, and brief follow-ups. Email is not to be used as a substitute for therapy, and does not replace a face-to-face session. You are advised to avoid including personal or sensitive information in your emails. The emails, or a summary thereof, become a part of your clinical record.

Emails and texts sent during scheduled work hours will be returned in 1 to 2 business days. Electronic communication is not intended for and is not appropriate for crisis situations. If you are experiencing a life or death crisis, or an urgent matter, please call your therapist, or call, or go, to the nearest emergency room and ask for the psychiatrist or psychologist on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a client and a mental health provider. In most situations, your therapist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Maryland law.

However, in the following situations, no authorization is required:

1. We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the client. The other professionals are also legally bound to keep the information confidential. If you do not object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Policies and Practices to Protect the Privacy of Patient Health Information). Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
2. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege law. We cannot provide any information without your written authorization, or a court order. If other adults are present at any sessions, we cannot release information about any joint sessions without the

written permission of all adults present at the sessions, or a court order. If you are involved in, or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.

3. If a government agency is requesting the information for health oversight activities, we may be required to provide it to them.
4. If a client files a complaint or lawsuit against your therapist, your therapist may disclose relevant information regarding that client in order to defend their self.
5. In most judicial proceedings, you have the right to prevent your therapist from providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your therapist's testimony if he/she determines that there is no privilege, or it has been waived.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. Our legal obligation involves the following:

1. If we have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect, or exploitation, the law requires that we file a report with the appropriate government agency, usually the local office of the Department of Social Services. Once such a report is filed, we may be required to provide additional information.
2. If we know that a client has a propensity for violence, and the client indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), we may be required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the client will carry out the threat, seeking hospitalization of the client, and/or informing the potential victim(s) or police about the threat.
3. If we believe that there is an imminent risk that a client will inflict serious physical harm or death on him/herself, or that immediate disclosure is required to provide for the client's emergency health care needs, we may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, your provider will make every effort to fully discuss it with you before taking any action, unless, in their professional judgment, there is a compelling reason not to do so. Your therapist will limit their disclosure to what is necessary.

While this written summary of exceptions to confidentiality should be helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and your therapist is not an attorney. In situations where specific advice is required, formal legal advice will be needed.

SOLE PROPRIETORSHIP

Warner & Associates, LLC IS a sole proprietor, and while we share office space with other mental health professionals, we operate independently, do not share responsibility for patients, nor do we share clinical information without proper consent of the patient.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in the form of a professional record, called the Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that disclosure is reasonably likely to endanger the life or physical safety of you or another person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in your therapist's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying preparation fee. If we refuse your request for access to your Clinical Records, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your provider amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. We are happy to discuss any of these rights with you.

You have the following rights in therapy:

1. To ask questions about your provider's treatment philosophy, experience with the problem at hand, your treatment plan, and the procedures used.
2. To seek a consultation regarding your treatment from another credentialed professional (we ask that you discuss this with your provider prior to seeking such a consultation).
3. To end therapy at any time without moral, legal, or financial obligation beyond payment due for completed sessions.

Should you decide between sessions to withdraw from receiving services, you should attend at least one additional session to discuss your reasons with your provider, so that you and your provider may properly bring closure to your work together. Treatment termination can sometimes be the result of misinterpretation, miscommunication, and the painfulness of the material under discussion. We encourage open communication before a final decision is made.

MINORS AND PARENTS

Patients under 16 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment and service records. While privacy in mental health services is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually our policy to request an agreement from any patient between 16 and 18 and his/her parents allowing us to share general information about the

progress of treatment and their child's attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger, or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections that he/she may have.

INVOLVEMENT IN OTHER THERAPIES OR EVALUATION SERVICES

As a condition of being in treatment with us, please do not undertake any other form of simultaneous therapy or evaluation without first bringing it up for discussion and mutual decision making. When another form of mental health service is undertaken, we require that open mutual releases of information be maintained with the other treating professional(s) to facilitate communication. As your primary provider, your therapist has professional responsibility for your overall psychological treatment, and additional therapy should be coordinated within the main treatment framework.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

Returned checks are subject to a $35 fee. If your account has not been paid for more than 90 days, and suitable arrangements for payment have not been agreed upon, we have the option of suspending or discontinuing treatment, and/or using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, dates, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Warner & Associates, LLC does not participate with any insurance companies. We will provide you with an invoice to submit to your insurance company or flexible spending account for reimbursement, according to your individual health insurance plan benefits.

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience, and will be happy to attempt to help you in understanding the information required by your insurance company for reimbursement.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA FORM DESCRIBED ABOVE.

_____
Client Name

_____
Client Signature (if 18 or over)

_____ _____
Parent/Guardian Name (if applicable) Date

_____
Parent/Guardian Signature (if applicable)

_____ _____
Warner & Associates, LLC Staff Name Date

_____
Warner & Associates, LLC Staff Signature

Consent to Treatment

I acknowledge that I have received, have read, and understand the "General Information and Psychological Services Agreement." I have had my questions answered adequately at this time. I understand that I have the right to ask questions throughout the course of my assessment and/or treatment and may request an outside consultation. I also understand that the mental health provider may offer additional information about specific treatment issues and treatment methods on an as-needed basis during the course of my treatment or evaluation, and that I have the right to consent to or refuse such treatment.

I understand that I can expect regular review of treatment to determine whether treatment goals are being met. I agree to be actively involved in the treatment, and in the review process. No promises have been made as to the results of this treatment or evaluation, or of any procedures utilized within it. I further understand that I may stop my treatment or evaluation at any time, but agree to discuss this decision first with my mental health provider. My only obligation, should I decide to stop treatment, is to pay for the services I have already received, and to attend one final session to discuss my reasons and to terminate.

I have been informed that I must give 24 hours notice to cancel an appointment, and that I will be charged $80 if I do not cancel or show up for a scheduled session.

I am aware that I must authorize the mental health provider in writing to release information about my treatment, but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once I release information to insurance companies or any other third party, there is no guarantee that it will remain confidential.

My signature signifies my understanding and agreement with these issues, and with the additional information conveyed in this statement.

_____ _____

Client Name Date

_____

Client Signature (if 18 or over)

_____ _____

Patient/Guardian Name (if applicable) Date

_____

Patient/Guardian Signature (if applicable)

_____ _____

Warner & Associates, LLC Staff Name Date

_____

Warner & Associates, LLC Signature

Please Print Client ID#: _____

Date: _____

Form completed by: _____

Relationship to child: _____

Child's Full Name: _____ M / F

Address: _____

City/State: _____ Zip: _____

Age: _____ Date of Birth: _____/ _____/_____ Grade in School: _____ GPA: _____

Ethnic Identification:
_____ African American/Black
_____ American Indian/Native American
_____ Asian-American/Pacific Islander
_____ Caucasian/White
_____ Latino/Hispanic
_____ Biracial/Multiracial
_____ Other: _____

PARENT INFORMATION

Parental Marital Status: _____ Never Married _____ Separated _____Widowed
_____ Married _____ Divorced_____ Other

Is custody being disputed in any legal action? Yes No

Parents are: _____ Birth parents _____ Foster parents
_____ Adoptive parents _____ Other

Who has physical custody? _____ Legal custody? _____

Mother's Name: _____ **DOB:** _____/ _____/_____ **Age:** _____
Address (if different from above): _____
City/State: _____ , _____ Zip: _____
Phone: Home(_____)_____ Work(_____)_____ Cell(_____)_____

Father's Name: _____ **DOB:** _____/ _____/_____ **Age:** _____

Address (if different from above): _____
City/State: _____ , _____ Zip: _____
Phone: Home(_____)_____ Work(_____)_____ Cell(_____)_____

If other than birth or adoptive parents:
Name of legal guardian(s): _____
Relationship to child: _____

Address (if different from above): _____
City/State: _____ , _____ Zip: _____
Phone: Home(_____)_____ Work(_____)_____ Cell(_____)_____

List all persons living in the home with the child:

Name	Age	Relationship to child

Reason(s) for coming for services today:

Services requested:

_____ Child/Adolescent Individual Therapy
_____ Child/Adolescent Group Therapy
_____ Psychological Evaluation/Testing
_____ Parent Counseling/Consultation
_____ School Consultation
_____ Other

Your acknowledgements:

I certify that the information provided above is complete and accurate.
I agree to notify my therapist if there are any changes in the above information.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Date: _____

MARYLAND NOTICE FORM

Notice of Policies and Practices to Protect the Privacy of Patient Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (PHI), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
    - Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
    - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
    - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization form from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes.

"Psychotherapy Notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – I may disclose protected health information regarding you if I reasonably believe that you are a victim of abuse, neglect, self-neglector exploitation.

- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another

individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. **Patient's Rights and Psychologist's Duties**

Patient's Rights

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy Notes unless I believe the disclosure of the record will be injurious to your health. On your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide you with the revised notice either in person or by mail and request that you review and re-sign the form acknowledging and consenting to the changes.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Beth S. Warner, Ph.D. at 301-442-3593.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to Beth S. Warner, Ph.D., 7303 Hanover Parkway, Suite C, Greenbelt, MD 20770.

You may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights.

You have specific rights under the Privacy Rule and I will not retaliate against you for exercising the right to file a complaint.

VI. Effective Date, Restriction, and Changes to Privacy Policy

This notice is effective as of April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person or by mail.

Warner Psychology Associates

Acknowledgement Form

I acknowledge that I have received a copy of the Notice of Policies and Practices to Protect the Privacy of Patient Health Information, effective April 14, 2003.

_____ _____

Client Printed Name (Parent/Guardian if client is a minor) Date

_____

Client Signature (Parent/Guardian if client is a minor)