NAME

TELEPHONE

DATE OF BIRTH

STREET ADDRESS

E-MAIL

CITY, STATE, ZIP

PERSON TO CONTACT/EMR.

PHONE/REL. TO PERSON

I would like Luke Geiger, LCSW, CSAC to work with me, or my family member, providing psychological treatment or testing. I understand that all information disclosed is confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I agree to pay Luke Geiger, LCSW, CSAC $100.00 per hour for 50 minute sessions and I understand that payment is due before services are provided. I understand that psychological testing will be charged according to the type of assessment needed. I understand that 24 hour notice of cancellation is required or I will be charged the full amount of the consultation. I understand that should my account become overdue, Luke Geiger, LCSW, CSAC may use a collection agency.

I understand that if I need additional support or I feel that my needs are not being met, Luke Geiger, LCSW, CSAC will provide referrals to other qualified practitioners.

My signature below indicates that I have read and understand this agreement.

SIGNATURE

DATE

WITNESS

DATE