Circle of Life Counseling, LLC

Acknowledgment of Informed Consent, Office Policies and Procedures and Professional Services Agreement, Mobile Payment Protocols, Financial Policies, and Texting Protocols

Informed Consent I/We have read and understand the risks and benefits related to evaluation and treatment. I consent to receive psychological and counseling services by Dorith Prutchi, MSS, LCSW. I have a copy of these policies and any questions regarding these policies have been answered.	_____ **Initial**
Office Policies and Procedures & Professional Services Agreement I/We have read and understand the Office Policies and Procedures and Professional Services Agreement. I agree to abide by these policies. I have a copy of these policies and agreement and any questions regarding them have been answered.	_____ **Initial**
Mobile App Payments I/We understand that, although not required by the Practice, if I/We choose to make payment to the Practice using Venmo, or any other form of mobile payment application, the Practice will utilize privacy settings, and I/We agree to also use privacy settings, to protect the privacy of our personal and financial information to the extent possible. I/We understand that no mobile application is completely secure and I/We voluntarily accept the risk of unauthorized disclosure of our personal and financial information in voluntarily using such payment methods.	_____ **Initial**
Financial Policies I/We have read and understand the Financial Policies and Procedures, including the late cancelation and no-show policies. I understand that I am the "financial guarantor", meaning that I will be responsible for payment of fees and charges at the time of service and that Circle of Life Counseling and Dorith Prutchi, MSS, LSW, are out-of-network except for straight Medicare. I agree to abide by these policies. I have a copy of these policies and any questions regarding these policies have been answered.	_____ **Initial**
Texting I/We understand that text messaging should only be used with the Practice for purposes of cancelling and rescheduling appointments and that the minimum personal information should be shared as text messaging is not secure. I/We understand that text messaging is not to be used for any other communications with the Practice.	_____ **Initial**

My/Our signature(s) below indicates that I/We confirm having read and understood, and do hereby consent and agree to comply with the policies and protocols outlined above. (All members of a family receiving services must sign separately.)

_____ _____ _____

Client Name (print) Client Signature Date

_____ _____ _____

Client Name (print) Authorized Representative Signature Date