CATALYST
COUNSELING

ACKNOWLEDGEMENT FORM

_____ _____ _____
Client Name Birth Date Email Address

_____
Street Address city zip code

Please initial the following:

_____ I acknowledge I have received a copy of my therapist's Disclosure Statement and Agreement for Services

_____ I acknowledge I have received a copy of the Catalyst Counseling HIPAA privacy policy

_____ I acknowledge that if I cancel an appointment with less than 24 hours' notice, I will be charged a cancellation fee of (initial one):
_____Individual sessions ($120)
_____Couples/family sessions ($160)
_____Open Path Sliding sessions (your quoted Open Path rate)

Consent for treatment
By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, that you have received a copy of the HIPAA and Washington State Notice of Rights and Privacy Practices and the Electronic Records Disclosure, have read and fully understand these rights, and have been given the opportunity to ask questions.
By signing this document, you are a attesting to your consent to participation in counseling services provided by:_____.
Therapist Name

_____ _____
Client signature Date

_____ _____ _____
Client Parent/Guardian Signature (if applicable) Client Parent/Guardian Printed Name Date

_____ _____
Therapist signature Date

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