Rachel Bernstein, LMFT, MSEd
16255 Ventura Blvd, Suite 806
Encino, CA 91436
818.907.0036
rbpsychology@gmail.com

Client Agreement:

Rachel Bernstein will be treating (name of client):

_____,

client's DOB _____, client's contact information _____

_____.

2. If there are additional clients I will be seeing along with the client listed above, please provide the name(s) of the client(s), date(s) of birth, and contact information. Please also list the relationship to the client listed above:

_____

_____

_____

3. If the client is a minor, please provide the name of the responsible party:

Name (printed)_____

Name (Signature)_____

Date of Birth_____

Contact information _____

Relationship to minor _____

4. If there is another person or persons who will be assisting this client with his/her treatment (helping with rides to and from, managing the schedule, and so forth) please put the person's or persons' name(s), address, and contact information below:

1._____
_____

2._____
_____

5. Fee Arrangement:

Payment is to be made at the time of service. Rachel's usual fee is $225 per 50 minute session. She reserves the right to adjust the fee periodically. Client will be notified of any fee adjustment in advance. The fee is to be paid at the time of service by cash, check, or credit card (MC or Visa). For help offered over the phone, or through video connection, a current credit card will be kept on file and will be charged. The amount charged will be on a prorated basis for time spent either providing counseling, consulting with other professionals on the client's behalf, speaking to others within that client's circle of family and friends who can help, for an extended session time agreed upon by the client, and for any other services requested of her within the purview of her usual treatment protocol.

6. Insurance:

Therapist will provide client with a statement containing all the required information and codes which client can submit to his/her insurance provider in order to receive any reimbursement of fees already paid.

7. Cancellation Policy:

Client is responsible for payment of fee for any missed session(s) without prior notice. Client is also responsible for payment of the fee for any session for which there was less than 24-hour notice of cancellation.

8. Acknowledgment:

By signing below, client, or minor client's representative, acknowledges that he/she has reviewed and fully understands the terms and conditions of this agreement. Client, or minor client's representative, agrees to abide by the terms and conditions of this agreement and consents to participate in psychotherapy with therapist. Moreover, client, or minor client's representative, agrees to hold therapist free and harmless from any claims, demands, or suits for damages from any injury or complications whatsoever, save negligence, that may result from such treatment.

Client: (please print) _____

(signature) _____

Name of minor client's representative:

(print) _____

(signature of representative) _____

Date: _____

9. I understand I am financially responsible to therapist for all charges:

Name of client: (please print) _____

(signature) _____

Date: _____

Name of responsible party for minor client:

(print name): _____

(signature): _____

Date: _____