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Introduction to Counseling and Informed Consent for Treatment

Welcome and thank you for considering me in the treatment of your mental health needs. I realize that starting counseling is a major decision and you may have many questions. This document (referred to as the Agreement) is intended to inform you of my policies, state and federal laws and your rights as a client. Please read it carefully and jot down any questions you may have so that those questions may be discussed at your first counseling session. When you sign the Acknowledgment of Informed Consent, it will represent an agreement between us that you are consenting to the terms included in this Agreement. This means you will be agreeing that you have read and understood what is contained in this document and agree to be bound by all the terms, conditions, and information it contains so please read over it carefully and we can discuss any questions you might have when we meet for your session. You may revoke your Agreement in writing at any time and that revocation is binding on me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

My Training and Approach to Treatment

I'm a Licensed Professional Counselor (LPC) and National Certified Counselor (NCC) specializing in individual and couples therapy using various evidence-based therapy techniques that are tailored to the individual and/or couples I'm working with. I received my Bachelor of Arts degree from the University of Texas at Austin and completed my Master's degree in Counseling & Psychology at the University of Mary-Hardin Baylor in 2009. I've completed multiple trainings in various counseling techniques but have specialized training and supervision from the Academy of Cognitive Therapy to provide competent and comprehensive Cognitive-Behavioral Therapy. I have over 12 years of experience working in the mental health field in various settings. I started working in private practice after years of work in hospital, non-profit, and community mental health settings.

I provide services for a broad range of personal and relational concerns focused on helping clients get to the root of their difficulties believe therapy is a collaborative relationship that begins with understanding you and your concerns.

The Therapy Process and Considerations

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, if you decide to continue with counseling. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Counseling involves a large commitment of time, money, and energy, so you should be very careful about the counselor you select.

Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for counseling to be most successful, you will have to work on things we talk about both during and outside of sessions such as homework like practicing therapeutic techniques, keeping a log of symptoms, and/or practicing new behaviors. If you have questions about my procedures, we should discuss them whenever they arise.

I use a variety of techniques in therapy, trying to find what will work best for you. These techniques are likely to include dialogue, interpretation, cognitive reframing, awareness exercises, self-monitoring experiments, visualization, journal keeping, drawing, and reading books. If I propose a specific technique that may have special risks attached, I will inform you of that, and discuss with you the risks and benefits of what I am suggesting.

I may suggest that you get involved in another therapy type or support group as part of your work with me or refer you to your primary care providers for health concerns or questions. If another health care person is working with you, I will need a release of information from you so that I can communicate freely with that person about your care.

Therapeutic Relationship

The relationship between therapist and client is the container through which change can take place. As such, the relationship is often one in which close emotional bonds develop. It is also a professional relationship, in which appropriate boundaries must be maintained. Limiting our relationship to the therapy office keeps your therapeutic environment safe, secure, and free of outside complications that could interfere with your therapy work. I do not have social or sexual relationships with clients or former clients because that would not only be unethical and illegal, it would be an abuse of the power I have as a therapist.

Also please note, if I were to encounter you in a public setting, in order not to reveal your connection to me as the therapist (and violating your right to confidentiality of others knowing you are in treatment), I will not acknowledge your presence unless addressed by you first.

Emotional Impact

Therapy is the Greek word for change. Therapy also has the potential to cause emotional risks. Approaching feelings or thoughts that you have tried not to think about for a long time may be painful. Making changes in your beliefs or behaviors can be scary, and sometimes disruptive to the relationships you already have. You may find your relationship with me to be a source of strong feelings, some of them possibly being painful at times.

It is important that you consider carefully whether these risks are worth the benefits to you of changing. Most people who take these risks find that therapy is helpful. But there are no guarantees of what you will experience and if you will feel better.

Length and Frequency of Sessions

The frequency of sessions and the length of the psychotherapy are aspects of the work that you and I will decide together as we proceed. Your initial session will involve an evaluation of your needs and depending on your circumstances further evaluative sessions may be required. I usually schedule these initial sessions for 90 minutes so we have time to go over any questions you might have for me or the documents you sign and to have time to cover any immediate areas of concern if needed. In general, I usually schedule one 60 minute session per week at a time we agree on, although some sessions may be longer or more frequent. For couples/marital counseling, sessions may be scheduled for a longer period of time as necessary, usually 60-90 minutes each week.

Ending Treatment

The number of sessions needed depends on many factors and will be discussed in our initial sessions together. You normally will be the one who makes the overall goal of when therapy will end, with some exceptions. If we have contracted for a specific short-term piece of work (for example a set number of sessions for an employee assistance program referral), we will plan to finish therapy at the end of that contract. If I am not in my judgment able to help you, because of the kind of problem you have or because my training and skills are, in my judgment, not within my scope of practice or outside of what I can provide as an outpatient therapist, I will inform you of this fact and refer you to another provider who may meet your needs more effectively.

If you do violence to, threaten, verbally or physically, or harass myself, the office and/or staff, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. For certain situations, I will work with you as part of a Behavior Contract we both agree to regarding acceptable behaviors and set consequences should the contract be violated again. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

Appointment Policy and Cancellation Fees:

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advanced notice of cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. My fee for ***late cancellation*** of a session without 24 hours advanced notice OR ***not showing up for an appointment*** without any call or message (a "no call/no show") at all is **$50.00**. If you "no call/no show" more than 3 times in a calendar year, I reserve the right to terminate our sessions.

Sessions are expected to begin and end at the scheduled time. Late arrival on your part will not extend the scheduled ending time for a session. I am also expected to be on time, and I will make appropriate remedy if I am late, such as by making up the time, prorating the fee, etc. If you arrive late to a session, the session will still end at the regular time.
Exceptions to this policy may be made at the therapist's discretion if there is no one waiting. If you will be late getting to a session, please call and leave a message indicating the reason. Arriving over 10 minutes late for a session multiple times can result in being charged a late cancellation fee of $50.

If it is possible, I will try to find another time to reschedule the appointment. Also, I understand that sometimes you may fall on financial hardship. Please contact me to discuss a payment arrangement for your account, should you fall behind, and I will do all that I can to help. If you are sick and might be *contagious*, please call and reschedule your appointment or you may be asked to wear a mask during our session. I generally do not penalize a client with fees if they are unable to attend due to illness that has potential to be contagious and encourage you to rest and practice self-care instead.

Methods of Contacting Me

By Phone:

Due to my schedule, I am often not immediately available by phone. While I am usually in my office during normal business hours, I will not answer the phone when I am with another patient. During my business hours, my phone is answered by a voicemail box or by the office manager. I will make every effort to return your call within **24 hours** of when it was received. Please be sure you leave your full name, a good phone number where you can be reached, and if there are times or days that are better for me to attempt to return your call. **I do not provide therapeutic services via telephone and only provide guidance in a brief manner until our next session.** If I will be unavailable for an extended period of time, I will provide you with the name of a colleague to contact, if necessary.

By Email and/or Secure Message Portal:

At times, it is most convenient for a client to contact me via e-mail to confirm an appointment, ask a question, or request a letter, etc. I am ok with this method of communication, but please understand **that I WILL NOT** provide therapeutic services via e-mail. It is important that you understand that e-mail is not a secure way of communicating and if you choose to communicate with me in this way, elements of your personal information may be vulnerable. I, of course, have my e- mail and phone password protected, but this alone does not guarantee the safety of your information. **I do not respond to text messaging of any kind that is not within the scope of confirming, changing, or scheduling an appointment or clarification questions related to non-therapeutic issues as it is unsecured and I cannot guarantee your information can be kept confidential and HIPAA compliant.** I instead will be encouraging the use of the secure client messaging service discussed below as a protected form of communication.

Please note: I use a secure client messaging portal (Simple Practice) that allows clients to message me in a secure manner and allows me to share files and handouts back with them all in a secure, HIPAA compliant manner. This will be an option to reach me with questions or updates outside of our sessions especially after my office hours.

For Emergency/Crisis:

As an outpatient therapist, I provide treatment for non-emergency situations. Situations or crises that are life-threatening, including suicidal thoughts with a plan and/or plan or intent to harm others, need to be treated in an environment equipped to handle those situations. If you feel you are a risk to yourself or to others please utilize emergency phone numbers or services to get immediate treatment for your situation and we can always follow-up together after your emergency has been able to be addressed.

In case of an emergency, please call **911**, your primary care doctor, **go to the nearest emergency room,** or you can **call various crisis hotline options** such as those listed here:

- □ **National Suicide Prevention Lifeline -** 1-800-273-8255 (available 24 hours a day)
- □ **Travis County Hotline to Help-** (512) 472-HELP (4357) (available 24 hours a day)
- □ **Crisis Textline (on smartphone)-** Text **HOME** to **741741** in the US to text with a trained Crisis Counselor

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise in advance, or unless you have insurance coverage that requires another arrangement. If you have insurance coverage, your co-payment or co- insurance is due at the time of service. By consenting to treatment, you acknowledge that you are responsible for the cost of these provided services (to you or your minor child) and agree to pay them when billed or at the time of services.

You are responsible for knowing what costs you will be accountable for paying if you utilize insurance benefits. Myself and my office manager can offer to discuss your costs and expected payments with your insurance company however you are still responsible to pay the total costs that insurance provides as the client responsibility even if it differs from what you are quoted when we check eligibility and costs for you as it is provided as a courtesy and is subject to change.

My usual and customary fee for the initial consultation with treatment planning and diagnostic assessment is: **$120.00**. The fee for a 60 minute individual therapy session is $**90.00**. The fee for a 60 to 90 minute couples/marital therapy session is: $**90.00**. In addition to our appointments, I may charge $90.00 per hour for any additional services you may request of me (e.g. consulting with other professionals about your case, preparing records, etc.).

I am currently able to accept cash, checks, debit and credit cards (VISA, MasterCard, American Express, Discover). Please note you may be requested to complete an Credit Card Authorization form to give consent to charge sessions on a recurring basis to a designated credit card as well as any other charges that might be incurred through the course of therapy (no-show fees, insurance copays, etc). A receipt will be provided for insurance or income tax purposes (usually via email). If using a check, please make them payable to "**Amy Urbanek, LPC, NCC".** Payments will be taken at each session so please have checks made out and ready at that time. In the event that your payment is denied or returned due to insufficient funds, there will be a $25.00 returned check fee.

If services are not paid in session, **then you agree to pay the service charge within 30 days notice**. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I will need to release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Legal Involvement:

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

Because of the difficulty of legal involvement, I charge **$225.00** per hour for preparation and attendance at any legal proceeding. I reserve the right to change these fees and you will notified in advance before any fee changes occur.

Insurance Reimbursement

Please note: I am currently considered "in-network" with Cigna, Optum/United Healthcare, and SOME but not all Blue Cross/Blue Shield plans (I am not in-network with Magellan Behavioral Health which is often used by certain BCBS plans to manage their mental health benefits).

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. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. 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 administration. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company to the best of my ability. If it is necessary to clear confusion, my office will be willing to call the company on your behalf. **By law I am not allowed to waive deductible or co-payments**.

When discussing your mental health insurance benefits with your insurance, the most common billing codes (known as CPT codes) I use are: **90834** (for 45-50 minute sessions), **90837** (for 60 minute sessions), **90847** (for couples/marriage counseling), and the initial evaluation is billed as a **90791.** Some circumstances require "add on codes" but these are rare and we would discuss if this were to come up as a concern

It is important to remember that if you choose to utilize your insurance, I will be obligated to provide them certain information about your case **including (but not necessarily limited to)** a diagnosis, type and dates of service. By assigning insurance benefits to my practice you are authorizing me to provide your insurance carrier (or their intermediary) whatever information is necessary to process the claim. If at any time, you have questions about the fees or insurance, please feel free to discuss them with me.

Documentation Services and Form Completion

If you need me to complete forms unrelated to billing needs or insurance authorization purposes, there may be a fee based on the time spent completing the documentation. For letters regarding service/emotional support animals, documentation of diagnosis, or confirmation of being in treatment, there is no charge. If documentation requires a record review and additional research requiring more than 60 minutes of my time, then there may be a $25 charge for each hour for completing letters or forms. **I do not complete forms related to Social Security disability determination, evaluation of ability to return to work, or forms regarding extended amounts of leave of absence from work.** These need to go to provider with the ability to document medical need for these circumstances. **I am willing to provide documentation or complete forms (if I determine it to be appropriate) for Family Medical Leave (FMLA) regarding intermittent leave time, work or school excuses for appointments, and paperwork for work or school accommodations due to mental health need.** I can complete forms for workplace short-term disability at times but recommend utilizing your medical provider resources for these forms and I usually will provide documentation that may "support" a disability claim. **I will need a signed Authorization to Release Information for ANY entity requesting information regarding your treatment before I will discuss any case, release therapy records, or review any treatment with other providers or other third party representatives.** Please be aware this can delay my response to those requesting forms, medical records, or a case review with a third party if these forms are not signed beforehand so please request a Release of Information form from myself or whomever might be needing your information as soon as you are aware you may need me to assist in these matters.

Notice of Privacy Practice

CLIENT RIGHTS AND CONFIDENTIALITY

HIPAA & Your Right to Confidentiality

The law protects the privacy of all communications between a patient and a psychotherapist. In most situations, the 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. The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, or health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of your protected health information for treatment, payment, or health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information before I can begin treatment.

Limits of Confidentiality

I respect the privacy of the information you provide me, and I abide by ethical and legal requirements of confidentiality and privacy of records. It is your right that our sessions and my records about you be kept private. In all but a few rare situations, your confidentiality is protected by state law, the rules of my profession, and my personal integrity. Texas state law requires me to inform you that in certain cases your confidentiality is not protected, and your information may be disclosed to the appropriate authorities/agencies. These cases are:

- If I have reason to believe that you may harm yourself or others,
- If I have reason to believe that you are involved in or have knowledge of abuse or neglect of a child; or abuse, neglect, or exploitation of a person who is elderly or has a disability, or
- If I am ordered to disclose by state or federal courts.

Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non- emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed. Some progress notes and reports are dictated/typed within the clinic or by outside sources specializing in (and held accountable for) such procedures.

In the event the clinic or mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality.

You have the right to cancel a release of information by providing me with a written notice. If you desire to have your information sent to a location different than the address I have for you on file, you must provide this information in writing. You have the right to restrict what information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them. You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

Additionally, I may disclose information if you sign a release form granting permission to designated third parties to receive information that you request me to share.

Rights Regarding Clinical Records

The laws and standards of the counseling profession require that I keep records regarding treatment and personal health information about you in your Clinical Record. The clinical records that I maintain on you are the property of my counseling practice. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your Clinical Record if you request it in writing.

The procedures for obtaining a copy of your medical information are by requesting a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial.
Records for non-emancipated minors must be requested by their custodial parents or legal guardians.

Requesting records for yourself:

You are entitled to receive a copy of the records unless I believe that seeing them would be physically, mentally, or emotionally damaging. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For that reason, you have the right to ask me to review your records with you. If you would like a copy of your record, I will provide the first 5 pages at no cost, then $0.10 per page after that. I am required by law to keep your records securely on file for 10 years following your last date of service, after which time they will be shredded.

Requesting records for another healthcare professional, attorney, facility, etc:

If you are requesting records so that you can give them to another professional entity like your primary care doctor, an attorney, or an insurance company, etc. you will first need to sign a release of information for me to send those records to the authorized person. If your doctor, attorney, insurance company, etc. are wanting your records, please let me know so I can fax or mail them and there will be no charge to you.

Other Rights

You have the right to ask questions about anything that happens in therapy. I'm always willing to discuss how and why I've decided to do what I'm doing, and to look at alternatives that might work better. You can feel free to ask me to try something that you think will be helpful. You can ask me about my training for working with your concerns, and can request that I refer you to someone else if you decide I'm not the right therapist for you. You are free to leave therapy at any time.

My Responsibilities to You

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. You must let me know in writing if you change your mind.

Acknowledgement of Informed Consent

I,_____, voluntarily agree to receive (or for my child,_____, to receive)
(Printed Client or Parent/Guardian Name) (Printed child's name)

Mental Health assessment, treatment, or services, and authorize Amy Urbanek, LPC, NCC to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care (or my child's care), treatment, or services, and that I may stop such care, treatment, or services that I receive (or my child receives) at any time.

By signing this Acknowledgement of Informed Consent, I acknowledge that I have read, understood, and agreed to be bound by all the terms, conditions, and information it contains.

I understand my rights and responsibilities as a client (and/or my child's rights), and my therapist's responsibilities to me.

Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client/Guardian Signature:_____

Client/Guardian Printed Name:_____

Date:_____

If Client is a Minor:

Printed Client Name:_____

Relationship of Parent/Guardian to Minor: _____

Signature of Therapist:

_____ _____
Amy Urbanek, LPC, NCC Date

Consent for Contact Via Voicemail, Text and/or Email Messaging

Consent to Communicate Via Email

I have been informed of the risks of communicating via email as this method of communication is not completely secure and confidential.

Please **initial** one of the two contact options below:

_____ I DO authorize Amy Urbanek, LPC, NCC to communicate with me (or about me with individuals that I have consented to) via email.

Primary Email Address: _____

_____ I DO NOT authorize Amy Urbanek, LPC, NCC to communicate with me (or about me with individuals that I have consented to) via email.

Consent to Communicate Via Text Message

I have been informed of the risks of communicating via text message as this method of communication is not completely secure and confidential.

Please **initial** one of the two contact options below:

_____ I DO authorize Amy Urbanek, LPC, NCC to communicate with me via text message on the phone number I have listed as my primary contact number..

Primary Contact Number: (____)_____

_____ I DO NOT authorize Amy Urbanek, LPC, NCC to communicate with me via text message.

Consent for Leaving Voicemail

Please **initial** one of the two options below:

_____ I authorize Amy Urbanek, LPC, NCC to leave voicemail regarding return calls and appointments on the phone number I have listed as my primary contact number.

Primary Contact Number: (____)_____

_____ I DO NOT authorize Amy Urbanek, LPC, NCC to leave a voicemail of any kind on the primary contact number I have listed. If I choose to receive voicemail in the future, I understand I will have to provide written consent.

Please provide a signature that you've agreed to these terms:

_____	_____	_____
Printed Name	Signature	Date

(Updated February 2019)

Authorization to Charge Credit Card

Purpose of this form:
This authorization form is kept on file to use to authorize processing payments over the phone and/or through electronic processing methods (such as Square or Stripe programs) for recurring session charges, balances that are over 60 days past the last date of service, and for late cancellation/no-show fees. This authorization may also be used to process payments related to balances incurred due to insurance changes or fees. If this situation occurs, the client will be informed of these charges before the payment is processed and given the opportunity of alternative methods of payment until 60 days past of being notified.

Client Name: _____
First Middle Initial Last

Name if it appears differently on the credit card:_____
First Middle Last

Address Associated with Card for Billing: _____

_____
City State Zip Code

Credit Card Information:

Card Type: _____ Mastercard _____Visa _____Discover _____American Express

_____Other (please explain)_____

Card Number: _____

Card Expiration Date: _____/_____

Security Code/CVV: _____

Authorization:
I authorize recurring charges on my card for any amount past due after 60 days of the last session with Amy Urbanek, LPC, NCC, PLLC. I understand an attempt will be made to inform me of these charges beforehand via phone, text, or email as authorized.

_____ (Initial)

I authorize Amy Urbanek, LPC, NCC, PLLC to process a potential charge of $50.00 for No-Show or Late Cancellation of a scheduled session which I will be informed of prior to being charged via text, phone call, or email as authorized.

_____(Initial)

I authorize Amy Urbanek, LPC, NCC, PLLC to charge balances due related to private pay costs, co-pay, deductible, or other insurance balances to my card and understand an attempt will be made to inform me of these charges before they are made via phone call, text, email, or in person as authorized.

_____(Initial)

Signature:
I understand this authorization will remain in place until I notify Amy Urbanek, LPC, NCC, PLLC in writing to revoke this authorization.

_____ _____ _____
Signature of Card Holder Printed Name Date

(Updated February 2019)

Acknowledgement of Receipt of HIPAA Privacy Policy

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 may have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the right to contest the claim under the policy. We are committed to protecting your privacy and affirm that it is our intention to comply with HIPAA and all other relevant federal, state, and local laws and our licensing board requirements to do so.

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

Name of Client:_____

Signature of Client (if 18 or over):_____

Date: _____