Cia Flodin, MEd
Licensed Mental Health Counselor

CLIENT AGREEMENT

Financially responsible party/parent please read & initial each agreement, then sign at the bottom.

_____ (Initial)
I authorize Cia Robles Flodin MEd LMHC to provide counseling and therapeutic services. No guarantees have been given by Cia Robles Flodin MEd LMHC as to the results that may be obtained. I indemnify and hold harmless the Cia Robles Flodin MEd LMHC from any and all claims arising directly or indirectly from the services rendered by said therapist under this agreement. Such indemnification shall include reasonable attorney fees and costs.

_____ (Initial)
I understand Cia Robles Flodin MEd LMHC does not offer services related to court or legal proceedings including verbal testimony, written statements or affidavits, unless court ordered by a Judge. If her participation is required for legal proceedings, I understand and agree to be charged $500 per hour with a minimum four hour charge paid in full prior to her participation.

_____ (Initial)
I agree to make full payment at time of service.

_____ (Initial)
I agree to pay a $15 late fee on all payments not received on the day of service. I understand the collection process will begin if full payment is not received within 60 days of service and this account will be assigned to Washington Collectors for immediate collection action.

_____ (Initial)
I agree to a pay a $40 fee on all checks returned for non-sufficient funds.

_____ (Initial)
I agree to pay the full clinical fee of $160 on all sessions missed or canceled with less than 24 hours notice, except in the case of emergency. Please note your insurance company will not pay this charge and as such, it is your responsibility.

_____ _____
Client Signature (Parental consent required for 12 and under) Date

_____
Print Name

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