Acknowledgement and Authorization

Tara Murphy, MA, LMFT
6701 Greenwood Ave N
Seattle, 98103

CLIENT NAME (printed): _____

Disclosure Statement and Consent to Treatment:

My signature below indicates I have received a copy of the required professional Disclosure Statement. I have read and understand the information provided and agree to receive counseling services from Tara Murphy, MA, LMFT. This includes understanding and agreeing to the billing policies, exceptions to confidentiality and the 24-hour cancellation policy. Without 24-hours' notice, I will be charged the session fee.

Client Signature: _____ Date: _____
Client Signature: _____ Date: _____
Parent/Guardian Signature (if applicable): _____
Therapist Signature: _____

Fee Agreement:

- ❑ I will be paying the service rate, $110/55 minutes.
- ❑ I will be paying a sliding scale rate of $_____/55 minutes.
- ❑ I will be using insurance. I have filled out the associated paperwork and agree to the financial policy.

Client Signature: _____ Date: _____
Client Signature: _____ Date: _____
Parent/Guardian Signature (if applicable): _____
Therapist Signature: _____

Notice of Privacy Practices:

My signature below indicates that I have been provided a copy of the Notification of Privacy Practices, outlined federal regulations governing the confidentiality of health records.

Client Signature: _____ Date: _____
Client Signature: _____ Date: _____
Parent/Guardian Signature (if applicable): _____
Therapist Signature: _____