Therapist – Patient Services Consent

My signature below indicates that I have received a copy of the THERAPIST-PATIENT SERVICES AGREEMENT (updated December 2020) and I agree to abide by its terms during our professional relationship.

My signature also serves as an acknowledgement that I have received the HIPAA notice form described in the agreement.

I also understand that 321 THERAPY may revise, supplement, or rescind policies, procedures or benefits described in the agreement, with or without notice.

Date ______________________

Name of Patient ____

Name of Parent or Legal Guardian ____

Signature of Parent or Legal Guardian ____