Kelly Trowbridge, PhD, LCSW, LSCSW
Transforming Praxis, LLC

Information Sheet
Consent to Treat
Receipt of HIPPA and Client Services Agreement

Name:_____ DOB:_____ Age: _____ Gender:_____

Home Address:_____

Cell Phone_____ Home Phone: _____Work Phone_____

Email:_____ Text appt confirmation or change okay? Yes No

What is the best way to leave you a confidential message?_____

Emergency Contact

Name:_____ Relationship: _____

Cell Phone_____ Home Phone: _____ Work Phone_____

Financial Responsibility Statement

I understand that Transforming Praxis does not participate with any insurance networks and payment is due at time of service. I will pay in full each visit at the following rate (please check one):

□ $120.00 per service hour (my family net income is $100,000+ annually)
□ $100.00 per service hour (my family net income is $50,000-100,00 annually)
□ $80.00 per service hour (my family net income is under $50, 000 annually)

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YOUR SIGNATURE BELOW INDICATES THAT THE CLIENT SERVICES AGREEMENT AND HIPAA PRIVACY NOTICE HAVE BEEN MADE AVAILABLE TO YOU & YOU HAVE READ AND UNDERSTAND THEM AND AGREE TO THE TERMS.

I hereby **acknowledge and consent to treatment** with Kelly Trowbridge, PhD, LCSW, LSCSW. I understand that I may discontinue services at any time I so choose.

Signature of Client Date Signed