Intake Form 2 of 3

HELLENIC THERAPY CENTER

567 Park Avenue, Suite 203 - Scotch Plains, New Jersey 07076 - (908) 322-0112

CONSENT FOR SERVICES/TREATMENTAGREEMENT

I, _____, hereby agree that I or my child/ward have voluntarily authorized and give full permission to the Hellenic Therapy Center to provide service/treatment, diagnostic evaluations and/or other services including medical/psychiatric treatment to me _____, my child/legal ward _____, as deemed necessary and appropriate by Hellenic Therapy Center. I understand that services at the Center may be discontinued at anytime by either party. In the event that I decide to discontinue services/treatment I understand that the Center encourages that a discussion about discharge take place between me and the Staff Personnel assigned to me.

Signature: _____ Date: _____

Witness: _____ Date: _____

CANCELLATION POLICY FINANCE AGREEMENT

If I fail to cancel a scheduled appointment within 24 hours, I hereby authorize that my credit card (or debit card) below will be charged the full professional fee for the service. Cancellation notice requires 24-hour advance consent and acknowledgement of the cancellation by the clinician with whom I am scheduled, or the Director.

I, _____, am authorizing Hellenic Psychology Center to use my credit card (or debit card) information to charge it according to the terms in this Cancellation Policy Agreement that I have reviewed and signed.

Card #_____ Expiration Date:_____

Name as Printed on Card: _____

Verification/Security Code (3 Digit Code on back of card by signature line):_____

Billing Address:_____

City: _____ State:_____

Zip:_____

Signature:_____ Date:_____