By signing this form,
I agree to pay $50/week, charged at the beginning of each month.

Please read and then initial:

________I understand that weekly attendance is agreed upon and that no refunds will be provided, regardless of my participation.

________I understand that my therapist will not contact any insurance company to report on my diagnosis, progress or my mental health status. I will take care of payments for group so that I am not limited by my insurance company on my access to care.

Name____

Email ____

Date of Birth ____

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Signature **Date**