



**Journeys Counseling**  
**CLIENT INTAKE FORM**  
(Continuation)

**PLEASE READ THE FOLLOWING CAREFULLY**

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought. \_\_\_\_\_ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions.

X \_\_\_\_\_  
CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X \_\_\_\_\_  
CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

X \_\_\_\_\_  
CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

X \_\_\_\_\_  
CLIENT/GUARDIAN SIGNATURE DATE

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_