



**THERAPY AGREEMENT**

**Contract for Mental Health/Family Therapy Services:**

I, (we) \_\_\_\_\_, hereinafter referred to as the Client(s), have this day retained Lauryn Salassi Gilliam, Ph.D. A.B.D., MFT, to provide psychotherapy/family therapy.

I, (we) hereby grant my (our) permission for any therapy and/or assessment evaluation that may be deemed appropriate by Ms. Gilliam.

I, (we) hereby understand that therapy sessions for myself and my family are strictly confidential. However, by law, Lauryn Salassi Gilliam is mandated to honor court orders and report any suspicion of abuse, neglect, homicidal or suicidal ideation.

It is expressly understood that Lauryn Salassi Gilliam has not issued, and will not issue, a guarantee of cure, of treatment effects, number of sessions necessary, or total cost of service. It is further understood that Mrs. Gilliam shall be obligated to maintain a reasonable standard of care for the field of mental health/family therapy.

I, (we) agree that: 1) the full fee of \$150 shall be due and paid at the time of treatment; 2) if the client does not give the clinic at least 24 hours notification of cancelling an appointment, the client will be responsible for a fee of \$150; and 3) Mrs Gilliam cannot guarantee around the clock availability for emergencies and it is the client(s) responsibility to access emergency care from 911 or other appropriate services should the need arise.

This agreement is entered into voluntarily by the Client(s) with the understanding, knowledge and responsibility contained herein.

Client's Signature

Date

Client's Signature

Date

**LAURYN SALASSI GILLIAM, Ph.D. A.B.D., MFT**