

Joy Robinson, RMFTI (FL Lic#1MT2398)
Phone: 786-423-2648

Supervisor: Marni Feuerman, LCSW, LMFT
Phone: 561-544-8011

7301 W. Palmetto Park Rd.
Suite 208B
Boca Raton, FL 33433

CLIENT AGREEMENT

I, _____, hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family. I understand that it is the policy of this office for the client to pay the therapist at the time of each office visit.

Supervision: I understand that Joy Robinson, RMFTI (Business Entity: Renew Your Life with Joy, LLC) is a registered marriage and family therapy intern under the Florida Board of Clinical Social Work. She is directly supervised by Marni Feuerman, LCSW, LMFT (business entity: Marni Feuerman, P.A.), Qualified LMFT and LCSW Supervisor. Joy Robinson, RMFTI is not an "employee" of Marni Feuerman, P.A.. Joy Robinson, RMFTI is an independent contractor using office space provided by Marni Feuerman, P.A. in order to complete her clinical hours toward full licensure in Florida. Any concerns or questions may be directed to Marni at 561-544-8011 during regular business hours.

Payment for Services: I understand that if my therapist offers sliding fee of \$_____ per session for professional services, mutually agreed upon prior to the start of treatment. Registered interns are unable to accept assignment of any insurance benefits whatsoever. I am responsible for paying this agreed upon rate at the time of service.

Cancellation: Because time has been reserved exclusively for me and/or my family, I understand that I am required to provide at least twenty-four (24) hours advance notice if I am unable to keep the scheduled appointment. Clients providing less than the twenty-four hour notice of cancellation will be financially responsible for the reserved appointment at the same rate agreed upon per session.

Release of Information: I hereby give full consent for Joy Robinson, RMFTI to freely discuss my treatment and review any records and/or treatment notes with Marni Feuerman, LCSW LMFT (Supervisor) in order to fulfill my obligation as a registered intern. I hereby also give consent for the therapist to report back to the professional(s) who referred me for the purpose of informing them that I have come here for treatment and to occasionally let them know how I am progressing and that I am continuing and/or terminating treatment with you. This consent DOES NOT cover the release of information that I may disclose within my treatment sessions. To disclose such information, an additional authorization form may be filled out.

Signature on File: Please accept a photocopy or fax of this authorization as if it were an original executed authorization.

Termination of Services: Services will be terminated upon mutual agreement between client and therapist based on need for continued services, transfer to another treatment setting or specialized treatment (i.e., rehab facility). If client has not scheduled an appointment within 60 days of the last office visit, he/she is considered officially discharged from this practice.

HIPPA/Notice of Privacy Practices: I acknowledge that I have received a copy and/or have been given an opportunity to read a copy of Marni Feuerman, P.A.'s Notice of Privacy Practices which cover any and all independent contractors using the office for the purpose of clinical social work, mental health counseling or marriage and family therapy. I understand that if I have any questions regarding the Notice or my privacy rights, I may contact the office at (561) 544-8011.

Attorneys' Fees, Governing Law, Venue: In the event either party shall incur attorneys' fees and costs with respect to the enforcement of this Agreement against the other party, prosecution or defense of any dispute hereunder, the prevailing party shall be entitled to recover from the non-prevailing party all reasonable attorneys' fees and costs (including costs and fees of litigation, insolvency, regulatory, bankruptcy or investigative proceeding appellate and post judgement proceedings and collection efforts) incurred by the prevailing party in any such action(s). This Agreement shall be governed by the laws of the State of Florida and any Federal laws which are applicable to the provider-patient relationship. The venue for any action filed in connection herewith by either party shall be in a court of competent jurisdiction in Palm Beach County, Florida.

NAME OF CLIENT (printed) _____

NAME OF PAYING PARTY (printed) _____

RELATIONSHIP TO CLIENT (printed) _____

SIGNATURE _____

DATE _____

(Signature of Client, Parent, Guardian or Personal Representative)