Katie McLean Hoar, LCSW
Firefly Counseling LLC
54 W. Twin Oaks Terrace, Unit 12
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O: 802.448.0830
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Therapeutic Agreement

Client full name: _____

Client date of birth: _____

I have read and understood the document entitled "Therapeutic Agreement." By signing here, I am agreeing to abide by its outlined terms and consenting to therapeutic treatment provided by Katie Hoar, LCSW. In addition, I understand that my signature below excludes me from using or subpoenaing Katie Hoar, LCSW and/or relevant files for court proceedings. I agree that a scanned or photocopied version of this agreement will be as valid as this original.

_____ _____
(Signature of Client) (Date)

_____ _____
(Signature of Parent/Guardian if minor) (Date)

For clients using health insurance:

I hereby grant authorization to Katie Hoar, LCSW to release any Protected Health Information (PHI) (except psychotherapy notes) that is necessary for billing, or to process my claim for payment of services, to my insurance company. I authorize my insurance company to send payment directly to Katie Hoar, LCSW for all services provided. I also agree that a photocopy of this authorization shall be as valid as the original.

_____ _____
(Signature of client, or parent/Guardian if minor) (Date)