

**Jo Anne Kaplan, MFT, Ph.D.** (Lic. #PSY 17126)  
**Franco E. Santos, MFTI** (Reg. #IMF 61114)  
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**Client Agreement / Consent for Services**

I hereby consent to and authorize mental health services to be provided by the offices of Jo Anne Kaplan, MFT, Ph.D. and Franco E. Santos, M.A., MFTI.

By signing this Client Agreement/Consent for Services, I consent, agree to and understand that:

1. I have the right to:
  - a. Be informed of and participate in the selection of evaluation, treatment, rehabilitative services.
  - b. Have the Notice of Privacy Practices presented and explained.

2. All Services are voluntary and I have the right to withdraw from services at any time. I further agree to and understand that should I decide to cease receiving services, I will remain responsible for the outstanding balance for services rendered until termination of services. (Please initial here to signify your agreement.) \_\_\_\_\_

3. I am responsible for my appointments. I further understand that should I wish to cancel an appointment, I am required to give notice at least 24 hours prior to my appointment time. Should I fail to cancel my appointment at least 24 hours prior to my appointment time, I agree to pay the agreed upon session rate as if I had been present during my appointment. (Please initial here to signify your agreement.) \_\_\_\_\_

4. Jo Anne Kaplan, MFT, Ph.D. and Franco E. Santos, M.A., MFTI value my confidentiality and that everything shared in session will not be disclosed without obtaining my written consent prior to such disclosure. However, I agree and understand that my right to confidentiality ceases when there is the possibility of: (a) child, elder, or dependent abuse; (b) I express any threat or harm to myself; and/or (c) I express any threat or harm to others. (Please initial here to signify your agreement.) \_\_\_\_\_

_____ Client Name (please type or print)	_____ Signature	_____ Date
Please complete below if client is a minor:		
_____ Name of Responsible Adult (please type or print)	_____ Signature of Responsible Adult	_____ Date

Relationship of adult to client: \_\_\_\_\_