



## Counseling Services Agreement

I, \_\_\_\_\_, on behalf of \_\_\_\_\_,

Legal Guardian

Client Name

have been given copies of the Counseling Services Information, Statement of Individual & Family Rights and Late Cancel/No Show Policy documents.

After discussing these forms with the OMC therapist, I understand and agree with the content of the Counseling Services Information, Statement of Individual & Family Rights and Late Cancel/No Show Policy.

\_\_\_\_\_  
**Signature of Individual Served** (if age 14 or older)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Legal Guardian** (please print)

\_\_\_\_\_  
**Relationship to Individual**

\_\_\_\_\_  
**Signature of Legal Guardian**

(Required if the individual served is a minor or an adult who is unable to sign this form)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Caregiver** (please print)

\_\_\_\_\_  
**Relationship to Individual**

\_\_\_\_\_  
**Signature of Caregiver**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of OMC Therapist** (please print)

\_\_\_\_\_  
**Signature of OMC Therapist**

\_\_\_\_\_  
**Date**

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