



Counseling Services Agreement

Client Name: _____

Date of Birth: _____

I 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.

Client Signature (if age 14 or older)

Date

Print Name of Legal Guardian

Relationship to Individual

Legal Guardian Signature

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

Date

Print Name of Caregiver (if different than legal guardian)

Relationship to Individual

Caregiver Signature (if different than legal guardian)

Date

Print Name of OMC Therapist

OMC Therapist Signature

Date

T 541.757.8068 F 541.758.1030 www.oldmillcenter.org

1650 SW 45th Place Corvallis, OR 97333

