Fara Murata LCSW
RAPHA COUNSELING CENTER
Office: 720-898-4800 Fax: 720-898-5169
www.raphacc.com

Agreement to Pay for Professional Services

I request that Fara Murata, LCSW provide professional services to me or to _____,

who is my _____ , and I agree to pay Fara Murata, LCSW the fee of

$ _____ per session/program for these services.

I agree that this financial relationship with Fara Murata, LCSW and will continue as long as she provides services or until I inform her, in person or by certified mail that I wish to end it. I agree to meet with Fara Murata, LCSW at least once before stopping therapy. I agree to pay for services provided to me (or this client) up until the time she or I end the relationship.

I agree that I am responsible for the charges for services provided by Fara Murata, LCSW to me (or this client), although other persons or insurance companies may make payments on my (or this client's) account.

I have also read this therapist's disclosure statement and fully understand the Information stated there, as shown by my signature below.

_____ _____

Signature of client (or person acting for client) Date

_____

Printed name

I, the therapist, have discussed the issues above with the client (and/or the person acting for the client). My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑Copy accepted by client ❑Copy kept by therapist