



Garet Bedrosian LCSW, CIRT, CBT, CET
Healing Relationships Around The Globe

Responsible Party if not Client Cell Phone Work Phone

Address City State Zip

Employer Phone Ext

Occupation SS# DOB

Fee Structure: Please speak with Gareth about fees.

Please pay fees and discuss scheduling or other business related issues at the beginning of each session so the remaining time can be used for your growth and healing.

Authorization to Treat: I authorize and direct Margaret "Garet" Bedrosian, LCSW, CIRT, CBT, CET to perform such therapeutic procedures that her professional judgment may indicate to be advisable for the well being of myself, my child and/or my family. I understand that no warranty or guarantee is made as to the results of this treatment.

I understand that insurance companies do not pay for missed appointments.

I agree to assume financial responsibility for the session fee charged for a failed appointment cancelled with less than 24 hours notice.

Please sign below if you agree to the stated terms.

Patient/Client Printed Name

Date

Signature