Lillybrook
In Times of Struggle, We Are Here

ACCT#: _____

PROFESSIONAL CONSULTATION CONSENT

Name_____ Date of Birth_____

Phone_____

Address_____ City_____ State _____ Zip code_____

Please Review the following:

I am aware that this is a professional consultation.

I understand that this meeting does not constitute therapy services and is utilized as an opportunity to meet a therapist and identify a need for ongoing therapy services.

I understand that the fee for a professional consultation is $100.00 and that fee is non-negotiable.

By signing below, I hereby acknowledge the above and consent to the professional consultation at Lillybrook Counseling Services

Signature_____ Date_____

Lillybrook Counseling Services
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