HELLENIC THERAPY CENTER

567 Park Avenue
Scotch Plains, New Jersey 07076
908-322-0112

CONSENT FOR SERVICES/TREATMENTAGREEMENT AND CANCELLATION POLICY

I, _____, hereby agree that I or my child/ward have voluntarily authorized and give full permission to the Hellenic Therapy Center to provide service/treatment, diagnostic evaluations and/or other services including medical/psychiatric treatment to me _____, my child/legal ward _____, as deemed necessary and appropriate by Hellenic Therapy Center. I understand that services at the Center may be discontinued at anytime by either party. In the event that I decide to discontinue services/treatment I understand that the Center encourages that a discussion about discharge take place between me and the Staff Personnel assigned to me.

If I fail to cancel a scheduled appointment and do not give 24 hour notice, I understand that I will be charged the full fee for missed or no show cancellations.

Signature: _____ Date: _____

Witness: _____ Date: _____