Your signature below indicates that you have read and understand the Informed Consent, Disclosure Statement, and other policies found at http://www.gapsychotherapy.org/policies.html and agree to abide by its terms during our professional relationship.

_____ ____ / _____ / _____

(Signature) (Date)

_____

(Print your name)

Please sign below to indicate that you have received a copy of the Professional Disclosure Statement and Pennsylvania Law on Client Rights & Clinician Responsibilities.

_____ ____ / _____ / _____

(Signature) (Date)