Kids On Up Psychotherapy, Inc.
101 Conner Drive, Suite 203
Chapel Hill, NC 27514
Phone: 919-240-5548 Fax: 919-525-1900

CLIENT AGREEMENT FOR SERVICES

I, _____, understand and accept all business policies of Solomon Kobes, LCSW. These policies include: office procedures regarding appointments, cancellations, messages, emergencies, fees, insurance, and confidentiality.

I grant consent for _____ to receive Outpatient Therapy from Solomon Kobes, LCSW. I understand that my consent to participate in this service is voluntary, and that my consent may be withdrawn with written notification at any time.

_____ _____
Signature **Date**

CONSENT TO SEEK EMERGENCY MEDICAL CARE

This is to authorize employees of Kids On Up Psychotherapy, Inc., if, in their judgement it is needed for _____. It is understood and agreed that employees of Kids On Up Psychotherapy, Inc. will be held harmless for any and all results of their efforts to obtain emergency medical treatment including accident or injury while being transported.

_____ _____
Signature **Date**