

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.

_____ / ____ / ____ / 2017
(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.

_____ / ____ / ____ / 2017
(Signature) (Date)