Authorization for Care

I, the undersigned, have received and read the Agreement for Psychotherapy Services provided by Tessa Suppes, LPC, and I authorize her to provide psychotherapy/counseling to me.

I understand that the psychotherapy services provided to me are by appointment only and may not be available on an emergency basis.

I am aware of the cancellation policy and know that I will be charged for a full session if I miss an appointment or cancel within 48 hours notice.

______________________________	______________________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________________	______________________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________________	______________________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________________	______________________________	__________
Tessa Suppes, LPC	PRINTED NAME	DATE