Dr. Ruthie Norman LICSW LLC
Trauma Treatment & Recovery Psychological Services

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Client Affidavit

I confirm that each of these sections in the Disclosure Statement & Agreement for Services Therapy Contract have been explained in a manner that is clear to me and that all questions I had regarding this contract, were answered to my satisfaction. I hereby attest that I have read, understand, and agree to Dr.Ruthie Norman, LICSW, LLC Disclosure Statement & Agreement for Services Therapy Contract.

Disclosure Statement & Agreement Contract Document

Contract Sections	
Contact	Consent to treatment
Therapeutic services	Consent to treatment for a minor
Attendance policy	Notice of privacy practices
Insurance reimbursement	Consent to treatment
Fees & payments	Electronic Signature
Court or legal involvement	Email & Text (SMS) Messaging
Confidentiality	
Privacy and confidentiality for a minor	
Parent involvement	

_____ ***I do NOT agree to the following section(s)***
(Initials)

My signature below authorizes Dr.Ruthie Norman, LICSW, LLC to provide psycho-therapeutic services determined to be clinically appropriate for myself, the client. I have read and understand the terms stated in this therapy contract form. I fully understand the scope of the services and confirm that this contract has been explained in a manner that is clear to me and that all questions I had regarding this document, were answered to my satisfaction.I agree to abide by the terms outlined and stated in this contract and throughout the course of our therapeutic relationship.

Parent/Guardian Name	Parent/Guardian Signature	Date
Client Name	Client Signature (If applicable)	Date