**Jennifer D. Nichols, MA, LPC-S**

Jennifer Nichols Counseling ~ 11711 Cypress N. Houston, Cypress, TX 77429 ~ (281) 323-2276

Jennifer Nichols Counseling

Property Destruction/Inappropriate Behavior Agreement

At Jennifer Nichols Counseling we strive to offer the most attractive, tranquil, healing and soothing environment possible while you and/or your loved one receives therapy. That is one of the things that separates us from many other clinics.

In order for us to accomplish this goal we need to make sure everyone respects other people here, the clinic and all property within and without.

Unless everyone does his or her part, we cannot continue to be the environment that we feel sets us apart

and that you know is a safe haven to come and improve your life.

Please read and sign below to indicate you understand your liability should property be damaged while you are

here or behaviors become disruptive to the point others are inconvenienced and/or the therapy of another is interrupted.

I understand that I am responsible for the cost of any property including all marketing materials, giveaways, furniture of any kind, artwork, rugs/carpets/floor, walls, fountains, plants, etc. that is destroyed while I or my loved one receives therapy. The minimal fee for destroyed property is $25.00 to be paid prior to you leaving the clinic. The cost will increase per the owner’s discretion based on the type and amount of property destroyed. **This policy also includes toys in the playroom/Sandtray Room valued at $25.00 or more for replacement value.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (Please Sign) Date

I understand that if while in the clinic my behavior or the behavior of my loved one becomes offensive and/or disruptive I/we may be asked to leave the clinic.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party (Please Sign) Date

Thank you for your cooperation!