

Larry D. Brooks Ph.D.
License # PSY 8161

-----Licensed Clinical Psychologist-----

Acknowledgment and Acceptance of Financial Responsibility

Last Name

First Name

Middle Initial

Date of Birth

Social Security # Insurance ID

Health Insurance

I, the undersigned, acknowledge that I am entering into a private agreement with Dr. Larry Brooks for mental health services that may include the following:

Couples therapy

Consultation

Family Therapy

Report preparation

Group therapy

Review of records

Individual psychotherapy

Psychological report

Other:

I accept full responsibility for the payment of mental health services that I have contracted with Dr. Larry Brooks.

I have read, understood, and agree to the above.

Signature

Date