

**DARLENE F. CROSS, M.S., M.F.T., Inc.**  
**Licensed Marriage & Family Therapist #0772**  
**(702)433-4411**

**TREATMENT AND FINANCIAL AGREEMENT**

I acknowledge that Darlene F. Cross provides services without discrimination based on race, gender, religion, national origin, or sexual orientation.

**I understand all information shared with Darlene is confidential and will not be revealed without my written consent, *except where state law requires reporting threats of violence, self-harm, harm to others, suspected child/elderly abuse, neglect, or when subpoenaed.***

***I further understand confidentiality cannot be ensured for electronic communications. I agree that in a medical emergency, I should call 911, not rely on messages left for Darlene.***

I request professional counseling services from Darlene for myself, my partner/spouse, or my family. I agree to pay \$180 per 50-minute session for individual treatment and \$200 per 50-minute session for couples and/or family treatment via cash, debit or credit card (\$5 courtesy fee for cards). Payment is due at time of service unless arranged otherwise. Patient records may be destroyed 5 years post-treatment, or thereafter.

**I understand that failure to cancel an appointment at least 24 BUSINESS hours in advance or failure to show up for a scheduled appointment will result in a full-fee charge.** (Emergency cancellations are considered individually.)

Patient agrees to indemnify Therapist against claims arising from treatment. Therapist will notify Patient of any claim and has the right to control the defense and settlement of such claims.

I understand that by signing this agreement, I am giving my voluntary consent to treatment and agreeing to the terms of this financial contract. My signature indicates that I agree to the terms of this contract and can request and receive a signed copy of this document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Revised 6/25