PLEASE READ THE POLICIES AND PROCEDURES.
It contains important information regarding your financial liability for services provided.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE REVIEWED THE AGREEMENT TITLED **"Policies and Procedures – Chapel Hill Psychiatric Associates, PA"** AND YOU AGREE TO ITS TERMS. THE LATEST POLICY IS AVAILABLE ON OUR WEBSITE WWW.CHAPELHILLPA.COM.

YOU MAY REQUEST A PRINTED COPY OF THE POLICIES AND PROCEDURES..

_____ _____

Signature of Client/Patient/or Patient's Legal Representative Date: