2124 Priest Bridge Dr., Ste 10
Crofton, MD 21114
410-451-3000 (phone)
410-630-7625 (fax)

Therapeutic Health Associates
Patient Agreement

I verify that I have read (or have had someone read to me) the information contained in the Therapeutic Health Associates Office and Financial Policies and understand the information presented including policies on communicating with the practice, missed and canceled appointments, emergencies, and medication refills.

I consent to undergo treatment, counseling, and/or diagnostic evaluation that may be deemed necessary by Therapeutic Health Associates.

I understand that treatment is a joint effort between Therapeutic Health Associates and myself, the results of which cannot be guaranteed.

I understand that I may end treatment at any time and that I can refuse any requests or recommendations made by Therapeutic Health Associates.

I agree to be personally and fully responsible for any financial charges related to services or fees as described in the policies.

Printed Name of Patient: _____ **DOB**: _____

Signature of Patient _____**Today's Date**: _____

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For Office Use Only:

Witness Name/ Title: _____

Witness Signature: _____ Date: _____