

Building Blocks Therapy Consent For Services

I, _____, give my permission to Building Blocks Therapy to exchange information with the following physicians, programs or other persons:

about, _____, whose date of birth is _____.

I also give permission for Building Blocks Therapy to provide evaluations, treatment, and consultative services to the above mentioned client.

I understand that fees for services provided are due at the end of each month or within ten (10) days of written invoice, and I hereby acknowledge that I have read and agree to the terms and conditions of the Terms of Payment Agreement attached hereto.

Name Printed

Date

Relationship to client

Virginia Address

450 West Broad Street, Suite 215
Falls Church, VA 22046
(703) 533-8819

DC Address

5125 MacArthur Boulevard, Suite 10
Washington, DC 20016
(202) 363-8255

www.buildingblockstherapy.com

Fax: (703) 533-7723

Electronic Mail: admin@buildingblockstherapy.com