



CONTRACT FOR SERVICES

MARGARITA GURRI, PH.D.
LICENSED PSYCHOLOGIST

Mailing: PO Box 1806 · Dania Beach FL 33004
Office: 7200 Griffin Road, Suite 3E · Davie FL 33314
954-609-9904 t · 954-530-8989 f · Margarita@ShrinkRapInc.com

Date: _____

Name of Client: _____ Date of Birth: _____

The following are the terms and considerations for services provided:

1. All fees are due at the time services are rendered.
2. Cancellations with less than 24-hour notice may be subject to a charge of the regular fee.
3. I acknowledge that I chose willingly to participate in, or have my child _____, participate in therapy, assessment, training, and coaching with the staff of **Shrink Rap, Inc.** and/or their designee.
4. I, including my heirs, executors, or administrators, agree to release and hold the staff of **Shrink Rap, Inc.** and/or their designee(s), harmless against any claims, demands, rights of action, or causes of action resulting or arising out of my or my child's participation in therapy/assessment/activities.
5. *In the course of training, practicum students, psychology interns, resident psychologists and psychologists new to our practice are required to shadow senior staff members. These individuals play a role and generally, simply observe and/or assist with data input, scoring and report preparation. Your signature below indicates that you are comfortable with the possibility of another "psychologist in training" being present during portions of your child's evaluation and at the final review, when results are shared with the parents.* _____
(initial)

1. Printed Name of Authorized Signature

1. Authorized Signature

Date

2. Printed Name of Authorized Signature

2. Authorized Signature

Date