

Watershed Counseling & Consultation Services, LLC
and **Grad School Coaching**
Jeanne L. Stanley, Ph.D.
(215) 397-7086
jeannelstanley@gmail.com

Structure-of-Service Agreement

Client Name: _____

Date: _____

Overview: This Structure-of-Services Agreement (the Agreement) is between the above-named client and Jeanne L. Stanley, Ph.D. regarding our work together in psychotherapy and / or coaching. This agreement begins on the date the form is signed, dated, and returned. The following information is to clarify our work together and to ensure you understand and are in agreement with the following information. If you have any questions or comments, please contact me.

This document (the Agreement) contains important information about my professional services, business policies, and how we will work together. I am also providing you with summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that I provide you with a Notice of The HIPAA Notice of Privacy Practices Statement (“The Notice”). A copy of The Notice is available in the waiting room and will also be provided to you for you to read and review. It is for use and disclosure of PHI for treatment, payment, and healthcare operations. The Notice explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. We can discuss any questions you have about the procedures at that time. After reading The Notice, please sign in the space presented later in this Agreement and it will represent an Agreement between us.

Nature of Working Relationship:

Counseling/Psychotherapy: My practice works with clients seeking psychotherapy/counseling services for personal and career issues. The purpose of our work is to help facilitate achievement of your individual therapy goals. We will work together to understand your strengths and assist you in moving forward. Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and client, and the particular concerns you are experiencing. There are many different methods I may use to work with you to assist you in addressing your concerns. Psychotherapy is different than a medical doctor visit. Instead, it calls for an active effort on your part. In order for the therapy to be most successful, you will have to work on areas we talk about both during our meetings and outside our time together. Thus, it is important for you to be honest in exploring what keeps you from making progress as well as what supports you in meeting your goals. Some clients need only a few meetings to address their specific goals, while others continue services for an extended period to explore and create ongoing change in their lives. Some clients chose to work on one or two goals through to completion, take a break and return if they want to address additional goals. We will discuss the kind and amount of services that best meet your needs.

My training and experience as a Counseling Psychologist is with clients seeking psychotherapy for counseling services often dealing with issues such as life transitions (relationship changes, career, and sociocultural identity issues) and mild to moderate anxiety and depression. For more clinical-based mental issues, such as bipolar, borderline and PTSD, I can provide you with referrals for Clinical Psychologists or Mental Health Providers with expertise in these areas rather than beginning our work and then having to refer you to someone with training and experience in these areas.

Psychotherapy can have benefits and risks. Since therapy can involve discussing unpleasant aspects of one’s life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have many benefits including better

relationships with others, solutions to specific problems and reduction in feelings of distress. There is no guarantees, however, of what will be your experience.

Our first few meetings will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include, and you can evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you want to be comfortable with the therapist you chose to work with. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to offer your referrals to another mental health professional.

Coaching (Graduate School / Career / Mid-Career / Executive): If your goals are specifically focused on graduate/professional school, career counseling or mid-career / executive coaching, our work will come from a more coaching-based approach and therefore may have a more structured and directive focus. Please also note in regard to Grad School Coaching, you as the client, choose which schools or positions to apply. Grad School Coaching does not guarantee acceptance or admittance into graduate schools, passing examinations, completing theses/dissertations, graduation, securing employment, or the completion of any other academic and career goals. We also do not contact schools on your behalf. You are responsible for your applications. For some clients, personal issues and concerns enter into their academic/career goals and therefore may also be of a counseling nature. The coaching and psychotherapy perspectives are not necessarily separate and mutually exclusive thus, the same ethical guidelines I use as a licensed psychologist are in place with our work together.

Scope and Limitations of Confidentiality: I value the confidentiality of information that you share with me, and I will make every effort to ensure that information about your case remains confidential. Please note, however, that there are legal and ethical exceptions to your right to confidentiality. If you have any questions about these limitations, you are welcome to ask me about them at any point during treatment. I will attempt to inform you in those rare cases that I would have to break confidentiality for the following reasons:

1. If I believe you are in imminent danger of harming yourself or that you are incapable of caring for yourself, I legally may break confidentiality. First, I will attempt to contact you and work with you to explore other options before needing to break confidentiality. If at that point you are unwilling to take steps to guarantee your safety, I will contact the police to ensure your safety and protection.
2. If I have good reason to believe that you present a specific and immediate threat of serious bodily injury to a specifically identified or a reasonably identifiable person or group of people, and you are likely to carry out the threat or intent, I am required to take protective actions, such as warning the potential victim(s), contacting the police, or initiating proceedings for hospitalization. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.
3. If I have good reason to believe you are abusing or neglecting a child or a vulnerable adult, or if you give me information about someone else doing so, I am obligated to inform Child Protective Services within 48 hours or Adult Protective Services immediately.
4. If you tell me of the behavior of another named health or mental health care provider who has either engaged in sexual contact with a client, including yourself, or is impaired in practice in some manner by cognitive, emotional, behavioral, or health problems, then the law requires me to report this person to the licensing board in the state in which they are licensed. I will try to inform you before taking this step. If you are my client *and* are seeing me because you are an impaired health or mental health care provider, however, your confidentiality remains protected from reporting under the law.
5. If I am ordered by a court to release your records, which sometimes happens when clients are plaintiffs in lawsuits in which psychological records are subpoenaed as part of that process, then I have no legal choice but to release your record to the court.
6. As part of the treatment process and to ensure that you are getting the best care that I can provide, I may discuss your case with my professional peer colleagues, but your name and other identifying information will be kept confidential in those discussions.
7. In the event that I die or become incapacitated, I have made arrangements for a colleague to review my records and ensure that clients I am working with receive notification and continued care.

Although not a legal exception to your confidentiality, I follow these same policies when working with couples in couples therapy. If you and/or your partner decide to have individual sessions as part of the couple's therapy, what you say in those individual sessions will be considered part of the couple's therapy and can be discussed in our joint sessions. In an individual session, please do not tell me anything you wish kept confidential from your partner as this would be counterproductive.

Please see the **HIPAA Notice of Privacy Practices Statement** for more specific information about your privacy under the HIPAA law.

Meeting Structure: Sessions are **50 minutes** in length (if you prefer, you may schedule an 80 minute session with the adjusted rate). In order for the sessions to be of optimal benefit to you, it is important that you arrive on time. If you are late for the session, we will still end on time so as not to run over into the next person's session time. Please note that the last five minutes of most sessions are summary and planning time.

Meetings in Person, Phone or Online Video: Appointments are set prior to each meeting and are held in person, by phone or by web-based video conferencing. Videoconferencing and phone meetings have potential benefits and risks that differ from in-person meetings. Every effort will be made to maintain confidentiality in regard to meetings by phone and/or internet, however, it is impossible to ensure complete confidentiality due to the nature of electronic communication. Confidentiality still applies and both you and I agree not to record the meeting. For videoconferencing & phone meetings, plan to be in a quiet, private space that is free of distractions (including cell phones or other devices) during the meeting. It is important to use a secure internet connection rather than public/free Wi-Fi. If you need to cancel or change your tele-appointment, notify me in advance by phone or email following the rescheduling/ cancellation policy described in this Agreement. In case of technical problems, we will use the back-up plan of you calling me at (215) 397-7086 to continue the meeting or to reschedule. Due to the remote nature of videoconferencing and phone meetings, we will also discuss a safety plan that includes at least one emergency contact, as well as the information for the closest emergency room to your location, in the event of a crisis situation. I retain the right to determine that due to certain circumstances, meeting by phone or video is no longer appropriate and that we should hold our sessions in-person.

Scheduling: Appointments are set based on time, date, and are usually in person, or via phone or video using a HIPAA compliant and secure online web video service. All scheduling changes must be made by telephone or text at **least 24 hours in advance of the session** so as not to be charged for a late cancellation.

Cancellation / Failure to Show Policy: Please contact me by telephone or text (215) 397-7086 as soon as possible and no later than 24 hours in advance to cancel or reschedule your appointment. If you cancel an appointment with shorter notice, it is not possible to schedule someone else for the time that was reserved for you. All clients, therefore, who cancel an appointment with less than 24 hours advanced notice or fail to show up without notice, will be required to pay the full session fee for the missed appointment and will have their credit card charged via Ivy Pay or be expected to pay by check for the missed appointment. Please note that insurance companies do not reimburse for missed appointments.

Telephone Calls, Correspondence by Email & Text Messaging: I am available for brief telephone calls (less than 5 minutes) between sessions during normal business hours of 9 am– 6 pm. If longer phone meetings are needed, the time will be prorated and count as meeting. Routinely, I return phone calls within 48 hours. If you leave a message on my voicemail, please state how late I may call you back (the latest being approximately 9:00 pm). If you are ever unable to reach me by phone and believe you cannot keep yourself safe or are in danger of hurting another person, call 911, or call the National Suicide Prevention Lifeline (800-273-TALK), or go to the nearest hospital emergency room immediately for assistance.

Email and text are available for brief messages regarding scheduling, changing appointments, billing matters, invoices, completed exercises, assignments, assignment updates and other non-therapeutic matters. Email and text are not a substitute for psychotherapy or coaching services, but a brief form of information exchange. Email or text messages are NOT to be used to communicate regarding *any* type of crisis or emergency. Please call and if I do not answer, call 911 or call the National Suicide Prevention Lifeline (800-273-TALK), or go to the nearest hospital emergency room immediately for assistance

Please note that you are protected under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA). This law ensures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (e.g., sending bills or brief email correspondence), it will be done from a private network with the goal of maintaining confidentiality. I also use firewall and antivirus software, which scans my computer and updates regularly. I strongly suggest that you only correspond with me by email from a private network with an active firewall and antivirus software as well. It is important to note, however, that it is impossible to ensure complete confidentiality due to the nature of electronic communication and data retrieval. For example, emails potentially are retained in the logs of our internet service providers (ISP). While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the ISP system administrators. Therefore, please do not email or text me about clinical matters or confidential information because this is not a secure way to communicate with me.

Social Media: I do not communicate with, link to, or contact any clients through social media platforms such as Twitter, Facebook and LinkedIn. If I discover that I have accidentally established an online connection with you, I will cancel that online connection. This is because these types of casual social contacts can create significant privacy risks. I participate in various social networks. If you have an online presence, there is a possibility that you may encounter me by accident. If that occurs, please discuss it with me during our time together. I believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact me in this way. I will not respond and will terminate any online contact.

Payment: Payment is to be made **prior to or at the beginning of each meeting**. I accept cash or credit card payment using *Ivy Pay*, which uses a secured server.

If paying by credit card, I use the payment service, *Ivy Pay* which uses a secure server to store credit cards (I do not have access to your credit card information. If you would like to pay by credit card using *Ivy Pay*, send me your **current cell number** so that *Ivy Pay* can send you the information to set up and process payments.

In addition to weekly appointments, I charge my full hourly fee for other professional services you may need, though I will prorate the hourly cost if working for periods of less than one hour. Other such professional services include report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your written permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be responsible to pay for all of my professional time, including preparation, transportation costs, and testimony time, even if I am called to testify by another party. Because of the challenges of legal involvement, I charge \$400 per hour for preparation and attendance at any legal proceeding.

Returned (bounced) checks: You are responsible for paying **all** fees incurred resulting from your returned (bounced) check. Please pay those fees plus the amount of the bounced check in cash to me by the next session after you have been notified that the check was returned due to insufficient funds.

Insurance Reimbursement: All professional services rendered by me are charged directly to you. This means that you are personally responsible for the payment of your therapy/coaching fee. I do not accept payment directly from insurance companies; however, clients are encouraged to contact their health insurance provider/company to inquire about reimbursement for an “out of network psychologist who is licensed in the state of Pennsylvania.” **Please remember that you are responsible for full payment at the time of the session.** Consequently, it is important you find out specifically what out-of-network mental health services are reimbursed by your insurance policy and if there is a limitation on the number of sessions for which your insurance provider/company will pay.

As stated in the section regarding your Protected Healthcare Information (PHI), some insurance companies require some information about your services, such as date of service, type of service (individual, group, couple) and a clinical diagnosis with code before they will cover your services. Therefore, if you ask for an invoice of your “paid” services to submit to your insurance company, the invoice will include date, type of service and a diagnosis with code. If you would like an invoice to submit to your insurance provider, you need to email or

mail me a written request stating the specific dates of treatment and an invoice in PDF form will be emailed to you. Please note, a missed session cannot be billed to an insurance company/provider.

Coverage While Away from the Office: Several times a year I will be away from the office providing trainings, consultation services, attending professional conferences, or vacation. If you feel you need a provider that is available most weeks of the year from Monday to Friday, please let me know and I will provide you referrals to providers that are in the office throughout most of the week in their individual or group practices.

If I am out of town, I will not be able to return your calls within the usual 48-hour time frame and will return your call when I return to the office. **Regardless of whether I am in or out of town, if you have a clinical emergency, if you believe that you cannot keep yourself safe, if you are in danger of hurting another person, and you are unable to reach me by telephone, call 911, call the National Suicide Prevention Lifeline (800-273-TALK), or go immediately to the nearest hospital emergency room for assistance.**

Service Termination Policy: Part of our work is deciding how long and how often we will meet. Typically, we will discuss session frequency and possible termination of our work together as we review your progress over time. You have the right to stop the work at any point. If you decide to end our work together, please notify me at least two sessions prior to our final session to allow us to bring closure to our work. In the event of fees owed at the time of termination, full payment is due prior to the final session.

If you cancel an appointment and do not reschedule or you miss an appointment without notice, and you do not respond to my outreach, I will assume you have terminated our ongoing work. If this happens, please feel free to contact me at any time about resuming treatment or finding alternative or follow-up care.

I also retain the right to terminate our work together based on my clinical judgment; I will give reasonable notice and will provide you with referrals, if appropriate. Thus, if you no longer need services, have attained your stated goals and objectives, or might be better served by other resources or a more intensive level of care, I may initiate a discussion with you about ending our work together. Actions on your part such as nonpayment, or situations that might compromise the safety and integrity of our work together, could also be cause for stopping. Ordinarily, I will attempt to discuss and resolve these matters with you prior to ending.

Websites: I have websites that you are free to access. I use them for professional purposes and to provide information. You are welcome to access and use the information on the websites. If you have questions about them, we can discuss this during your meeting.

Practice Affiliation: While I maintain a part-time faculty appointment at the University of Pennsylvania, my practice is not affiliated with the University of Pennsylvania. Likewise, although I share office space with other practitioners and collaborate with other professionals, my practice is not affiliated with them.

Please make a copy of this document so you may refer back to it. **Sign and return the following pages** to Jeanne Stanley in our next meeting together.

I look forward to our work together, thank you.

Watershed Counseling & Consultation Services, LLC
and **Grad School Coaching**
Jeanne L. Stanley, Ph.D.
(215) 397-7086
jeannelstanley@gmail.com

**Standard Notice: “Right to Receive a Good Faith Estimate of Expected Charges”
Under the No Surprises Act**

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don’t have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit:
www.cms.gov/nosurprises

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Client Agreement to the Structure-Of-Services of Jeanne L. Stanley, Ph.D.

Your signature below indicates that you have read, understood and agree to the terms of the Structure-of-Service Agreement.

Name of Client(s)

Signature of Client(s)

Date

Signature of Parent(s)/Legal Guardians of Minor Children or Other Legal Representative

Client Acknowledgement Of Receipt Of HIPAA Notice Of Privacy Practices

Pursuant to HIPAA, I am obligated to request that you (my client) sign an acknowledgment that you have received and reviewed my Notice of Privacy Practices to protect the privacy of your Personal Health Information.

Name of Client(s)

Signature of Client(s)

Date

Signature of Parent(s)/Legal Guardians of Minor Children or Other Legal Representative

(Please keep a copy of this signed form for your records)

**INFORMED CONSENT CHECKLIST FOR
TELEPSYCHOLOGICAL / COACHING SERVICES**

**Watershed Counseling & Consultation Services, LLC
and Grad School Coaching
Jeanne L. Stanley, Ph.D.**

Please keep the following in mind regarding video-conferencing or phone meetings (if you have any questions, please bring them up so we can discuss them):

- There are potential benefits and risks of video-conferencing / phone meetings (e.g. limits to client confidentiality) that differ from in-person meetings.
- Confidentiality still applies for telepsychology/coaching services, and nobody will record the meeting without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual meetings and if you have questions about how to use it, I will work to explain how to you.
- You need to use a webcam or smartphone during the meeting.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the meeting.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify me in advance by phone or email based on cancellation policy described above.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the meeting or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology / coaching meetings.
- As your Psychologist / Coach, I may determine that due to certain circumstances, telepsychology / coaching is no longer appropriate and that we should resume our meetings in-person or provide you with referrals for someone that you can see in person.

Please indicate that you have read, understand and agree to the above information regarding telepsychology /coaching by video conferencing or phone by signing below. If you have any questions, please contact me prior to our next meeting. Thank you.

Jeanne Stanley, Ph.D.

Client Name:

Signature of Client:

Date:

(Please keep a copy of this signed form for your records)

Watershed Counseling & Consultation Services, LLC
and **Grad School Coaching**
Jeanne L. Stanley, Ph.D.
(215) 397-7086

Client Information

Please complete this form and mail or bring it with you to your next meeting.

All information below is considered confidential and considered Personal Health Information (PHI).

Name:

Date:

Pronouns you use:

Date of Birth:

Current Age:

Email:

Phone Numbers: Please only leave phone numbers which you are okay with me calling

Cell Phone: **May I text you? Yes** _____ **No** _____

Home Phone:

Business Phone:

Indicate on which phone number you prefer to receive

Calls:

Messages:

Home Address:

Occupation(s)/Education:

Employer/School:

Relationship Status: ___ Not involved ___ Involved ___ Married/Domestic partner
 ___ Separated ___ Widowed ___ Other

If in relationship, name of partner(s) / Spouse (s):

If Child/Children, Name(s) and Age(s):

Parent(s) / Careprovider(s) Name(s) and Age(s) (indicate living or deceased):

Sibling(s) - Name(s) and Age(s) (indicate living or deceased):

Other significant extended family members:

Current living situation:

Friendship / Support systems:

Name / Phone Number of Emergency Contact Person:

Name / Address of Closest Emergency Room to Where You Live:

The Ways in Which You Self Identify:

Gender Identity/Identities:

Racial Identity/Identities:

Ethnic Identity/Identities:

Sexual Orientation(s):

Religious / Spiritual Identity/Identities:

Other Identity/Identities:

Are you involved in any current litigation and if so, briefly explain:

Referral Source/Who Recommended Me to You (if applicable):

Primary Care Physician or Internist (Name, Address, Telephone):

Psychiatrist / Psychiatric Nurse Practitioner (Name, Address, Telephone):

Counseling / Psychotherapy / Psychological Psychiatric Treatment History

Dates	Provider (Name, degree)	Type (outpatient, inpatient, group, AA)	Reason for treatment	Experience: Positive / Neutral / Negative

Current Mental Health (Check the concerns that you are currently experiencing or have experienced in the last month)

	Depression		Self-esteem		Anxiety
	Stress		Confidence		Loss of significant person
	Loneliness		Body image		Suicidal thoughts/ideation
	Procrastination		Guilt/shame		Sexual concerns
	Physical stress		Sexual identity (i.e. gay, lesbian, bisexual, queer)		Gender identity concerns (i.e. transgender, gender expansive)
	Sleeping difficulties		Friendship		Romantic relationship
	Concerns about your alcohol/drug use		Concerns about family members alcohol/drug use		Sexual addiction
	Test anxiety		Academic difficulties		Physical/Emotional/Sexual abuse
	Other:		Other:		Other:

Have you had suicidal thoughts and attempts in the past and/or present?

Do you feel yourself to be a burden to others?

Medical/Health History

Current and past medical issues (e.g., head injuries , migraines, high blood pressure, diabetes) and procedures (e.g. surgery):

Current Medications Including Psychopharmacological Prescriptions, Vitamins, Supplements, etc.:

Medication Name	Dosage	Purpose	Prescribing Doctor

Current and past substance use:

Substance	Current usage (amount, frequency)	Approximate dates (years) when used most intensely
Nicotine		
Alcohol		
Marijuana CBD		
Opioids/Methadone (Vicodin, Oxycontin, Heroin, etc.)		
Cocaine		
Methamphetamines (Ritalin, Speed, Ice, etc.)		
Benzodiazepines (Valium, Xanax, Ativan)		
Other: _____		
Have you been in treatment for your substance use?	Describe:	Treatment Facilities & Dates:

<p>What would you like to focus on in therapy and/or coaching and how would aspects of your life related to these goals be different for you when we complete our work?</p> <p>Goal 1:</p> <p>Goal 2:</p> <p>Goal 3:</p>

Any Additional Information that is Relevant:

(Please keep a copy of this completed agreement form for your records)

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jeannelstanley@gmail.com

Authorization for Release of Healthcare Information

(Complete/return this form only if you would like me to be able to communicate with the person you list below, otherwise you do not need to complete/return this form)

I, (Client) _____, with the Date of Birth of ___/___/_____,
authorize Jeanne L. Stanley, Ph.D. to obtain/release (circle one or both) the following information:

- Verbal overview with provider listed below
- Treatment summary
- Psychological evaluation/assessment results
- Other (as specified here): _____

From and/or to (Person or Facility): _____

Address _____

City/State/Zip _____

Phone _____

For the purpose of:

- Treatment planning
- Continuity of care
- Other (as specified here): _____

This consent will begin on _____
and expire

- At the end of treatment
- Other event (please specify) _____ Date: _____

I am aware that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule. I understand that I have a right to cancel this authorization by writing to Jeanne L. Stanley, Ph.D. at: jeannelstanley@gmail.com

I understand the nature of this release and agree.

Client's Signature: _____ Date: _____

(Please keep a copy of this signed form for your records)