LATRESA L. WILLIAMS, BSW, ACSW, LMSW
Licensed Clinical Therapist
31584 Schoolcraft Road
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Phone: 248.491.8417 Fax: 313.278.3690

Please take a few minutes to look over the following information. These important points will assist in making your visits here satisfactory. Please initial each item to indicate that you agree and understand the following:

CLIENT NAME: ____

______ Our front desk hours are as follows: Monday through Saturday 9:00 am – 4:00 pm with the exception of holidays and flexible agreed upon appointments to accommodate our clients.

______ Our answering service is available after hours every day to assist with emergencies.

______ Each client must check in at the window upon arrival and all payments are due at the time of check in.

______ Your clinician will go over the fees/co-pays/deductible with you during the first session. Any necessary adjustments will be made between you and your clinician.

______ If there is a change of insurance, you will need to inform our front desk and/or your therapist, failure to do so may result in being charged private pay fees for services rendered.

______ Please call 24-hours in advance if you need to cancel an appointment. Charges for no show appointments are the client's responsibility.

______ Please notify the office with any changes with your insurance or personal information.

______ I agree and understand all initialed items above.

____ ______________________

Client/Parent/Legal Guardian Signature Date

____ ______________________

Witness Signature Date