

Patient Allies Consulting

Client Agreement Form

I, _____, understand that Patient Allies Consulting **may or may not have direct contact or experience with practitioners and other resources I may be given for referral.** I understand that as a patient in control of my own care, it is my responsibility to thoroughly research all practitioners and resources before entering into services or treatment. Therefore, I agree not to hold Patient Allies liable should I have a less than positive experience with any of these resources.

I also understand that Nancy Jay is **not a professional therapist or counselor**, however she does have experience providing counseling to the chronically ill and will also provide supportive counseling as a peer with someone who has been through acute and chronic illness. If I feel I need psychological assessment and assistance beyond what Ms. Jay is able to provide, I will let her know immediately and allow her to assist me with finding these services. I understand Ms. Jay might also make a recommendation for me to have obtain professional psychological help should she feel this is the best and safest course of action for my care.

Today's Date: _____

Client Signature

Patient Allies Representative

Please fax this or email this form as soon as possible to:

**Nancy Jay
C/O Patient Allies
5126 N Granite Reef Rd
Scottsdale, AZ 85250**

***Please note it can take up to a week or more to receive this via mail. Therefore, I highly recommend you fax it to me..if faxing please call ahead so I can set up my machine for a specified time. Also.. please understand, I **CANNOT and WILL NOT begin working with you until I have this completed form in my hands.** It is for your protection and mine. Thanks for your understanding on this!*

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