Client Assumption of Liability Agreement

Client Name

Subscriber Name

Subscriber No.

By my signature below, I, _____, acknowledge that I have received a copy of the "Disclosure Statement and Therapy" that contains a notice of specific information regarding fees charged for services by Kane & Associates, LLC, Micheal Kane, Psy.D, MSW, LICSW, 2711 East Madison Street, Suite 206, Seattle, WA 98112. I acknowledge that I am financially responsible for all services rendered by this office visit and any subsequent office visits.

I understand and agree that any legal action arising under or related to this agreement shall be brought and maintained exclusively in a State court in Thurston County in the State of Washington and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of such action and hereby waive any defense relating to personal jurisdiction, process or venue bought in those courts.

Legal Action Clause

In the event of default of payment and/or failure to pay, I agree to pay the costs of collection, including court costs and reasonable attorney fees to be determined by a court of law.

Name | Relationship to Client

Signature of Responsible Party | Date

1 copy to Client/Responsible Party
1 copy to Client's file