EDUCATION/TREATMENT AGREEMENT

Client Name: _____

Client ID/SS#: _____

Agency Name: Wilson Place

You have selected the above agency to provide services at the level of care identified by your assessment. The following provides you with a schedule of times and fees for that service.

____ **20-hour Education**

Fee for this service: _____
Days of the week and time of sessions:

Day	**Time**
_____	_____
_____	_____
_____	_____

____ **Group Outpatient Treatment**

Fee for this service: _____
Day of the week and time of session:

Day	**Time**
_____	_____

____ **Individual Outpatient Treatment**

Fee for this service: _____
Day of the week and time of session:

Day	**Time**
_____	_____

I fully understand the schedule of services and fees required for my participation in the identified program. I agree to pay all fees in full and maintain regular attendance until the completion of my program. I understand that failure to complete the program or pay the fees assigned will result in a report of non-compliance being sent to the court by this agency and may result in a bench warrant being issued by the court.

_____ _____
Signature of client Date

_____ _____
Signature of agency representative Date