

**PASSAGES PROGRAM**  
**KANSAS CITY HOSPICE AND PALLIATIVE CARE**  
**POLICIES FOR PSYCHOTHERAPY SERVICES**

**AGREEMENT FOR SERVICES**

**Your signature below attests that you have read, discussed, understand, and agree to what has been stated above regarding privacy, confidentiality and billing and that you have received a copy of the Passages Program policies.**

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**Print your name**

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**Sign your name**

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**Date**