Leah McNulty, LCSW
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Please read this document in full prior to signing as we will review it in your initial session.

CLIENT CONSENT FOR SERVICES

You have been provided with copies of **Notice of Privacy Practices, Practice Policies, and Summary of Client Rights** via the Client Portal or in person at the office of Leah McNulty, LCSW. Please ensure you have reviewed those documents prior to completing this form, and feel free to ask any questions as to how this information may affect you.

Please read the following statements and sign below:

- I have received a copy of the Notice of Privacy Practices, Practice Policies, and Summary of Client Rights. I understand that I can access the most current version of these documents online at leahmcnulty.com, request a copy from my therapist, or find a printed copy in the office.
- I consent to the evaluation and treatment of mental health services, including consultation, evaluation/ assessment, treatment planning, and psychotherapy.
- If I am a parent or guardian/conservator of a client who is a minor (under age 18), I understand that by providing my consent on this form, I am either stating I have the legal ability to independently consent for psychological services on behalf of the client, or I have informed the therapist of additional parties responsible for consenting to psychological services and obtained any necessary documentation per legal custody order in place.
- I have read the Notice of Privacy Practices. I understand how my PHI (protected health information) may be used and shared. I am aware that if my therapist suspects potential child or elder abuse or has been given reason to believe a client may harm themselves or others, the therapist may be legally obligated to breach confidentiality and notify appropriate individuals or authorities (such as a designated emergency contact or CPS).
- I understand that my therapist may need to consult with other professionals in their areas of expertise in order to provide the best treatment for me. Information about me may be shared in this context without using my name.
- I understand the risks and limitations to confidentiality with the use of electronic correspondence, including email, text, and scheduling. I understand that I can choose to limit communication to phone and in-person correspondence. I may also access encrypted messaging and communication with my therapist through the client portal.

- I agree to pay the established fees for services at the beginning of each session. If I am a private pay client and I wish to obtain insurance reimbursement, I understand it is my responsibility to request a superbill. If I am using insurance, I understand that it is my responsibility to keep all insurance information up-to-date on my Headway profile.
- I have read and understand the cancellation policy, which states that if I cancel an appointment within 24 hours of the scheduled appointment time instead of prior, I will be charged a cancellation fee of $25. I understand that if I do not cancel in advance and neglect to attend the session, I will be charged $75. I understand the fee is due at the time of the scheduled appointment and my credit card on file will be charged.
- I agree to the policies regarding social media and other online activity and understand the boundaries established between the therapist and the client.
- I agree to the requirements set forth for online and phone therapy sessions. I also understand that this method of therapy is not appropriate for all individuals, and that I will be provided with referrals if another option is more appropriate for me.

By signing this form, I certify:

- That I have read or had this form read and/or explained to me.
- That I fully understand its contents.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

______________________	______________________	______________
Printed Name of Client	Signature of Client	Date
Printed Name of Parent/Guardian (if client is a minor)	Signature of Client	Date
Printed Name of Parent/Guardian (if client is a minor)	Signature of Client	Date
Printed Name of Clinician	Signature of Clinician	Date