Jean A. Leahy, Psy.D.

Licensed Clinical Psychologist

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312-494-1660

645 N. Michigan Ave
Suite 803
Chicago, IL 60611

PATIENT TREATMENT CONSENT

Please Initial Each Statement Below:

_____ I have received, read, and signed the form entitled **Psychotherapy-Patient Service Agreement** and agree to abide by Dr. Leahy's practice policies. If at any time I have questions about the subjects discussed in the handouts, I can talk with Dr. Leahy about my concerns. I understand that I am not waiving any rights. I understand that I have the right not to sign this form.

_____ I have received, read, and signed the form entitled **HIPAA Notice of Privacy Practices** and agree to abide by Dr. Leahy's practice policies.

_____ I have received, read, and signed the **Informed Consent for Telepsychology**, in which psychotherapy can be performed using the phone or the internet, and agree to abide by Dr. Leahy's practice policies.

_____ I understand that I am responsible for contacting my insurance company and understanding the terms of my insurance. I understand that my employer's Human Resources department may provide me with assistance in that endeavor and in other dealings with my insurance company.

_____ I understand that I am responsible for full payment for the services provided to me. Payment is due at time of service unless a contractual relationship between Dr. Leahy and the insurance company requires a different arrangement. If I become more than 30 days in arrears of payment for which I am responsible, my therapy may be terminated or suspended until payment is received or a payment plan has been agreed upon and honored.

_____ I understand that **cancellations of appointments must be made at least 24 hours in advance** of the scheduled session. If I do not contact Dr. Leahy to cancel or fail to show, I will be charged the full fee for the appointment. Insurance does NOT cover such fees.

_____ I understand that time is reserved for me. If I arrive late, Dr. Leahy may not be able to extend the appointment, and I am responsible for the full fee.

_____ I understand that if I become more than 60 days in arrears and alternate payment arrangements have not been made and honored, a collection agency may be used to secure payment.

_____ I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY FOR THE FILING WITH INSURANCE COMPANIES AND/OR THEIR PAYMENT FOR SERVICES. IF I AM USING INSURANCE FOR WHICH DR. LEAHY IS IN-NETWORK, I AUTHORIZE PAYMENT OF THIRD-PARTY BENEFITS TO JEAN A. LEAHY, PSY.D..

Dr. Leahy has explained all policies and answered all of my questions regarding this treatment consent.

Patient Signature	Date
Patient Printed Name	Jean A. Leahy, Psy.D. / IL. License #071.004900