Jennifer L. Harkins, LPC, PLLC

CONSENT TO TREATMENT

- ✓ I have read, understand, and been given a copy of the Client information on Office Practice and Policies
- ✓ I have received a copy of the Notice of Privacy Practices (HIPAA-related)
- ✓ I give my consent to treatment by Jennifer L. Harkins, LPC, PLLC
- ✓ If I want to use insurance, I authorize Jennifer Harkins to file for my insurance and to accept assignment of insurance payment for her services unless otherwise specified above
- ✓ I understand that if I use insurance, Jennifer Harkins may be required to communicate with representatives of my insurance carrier.
- ✓ If my insurance company or managed care company does not cover services I realize that I am responsible for all fees for services provided
- ✓ If I have any concerns or complaints about my treatment, I understand I should talk with Jennifer Harkins about my concerns.
- ✓ Clients who have not had a session in over 45 days (or within a mutually agreed upon time) will be considered inactive. It is always preferable to have a final session before ending therapy in order to review and evaluate the sessions and assess overall progress. Please be fully assured that anyone wishing to return to active therapy can do so by contacting me to make arrangements at any time.

Client Name: _____

Signature: _____ Date: _____

(If applicable)
I further consent to the evaluation and/or treatment of my minor child in my legal custody or guardianship.

Signature of Guardian: _____ Date _____

Signature of Jennifer Harkins:_____ Date_____