Lisa A. Lenhart, PhD, LLC 100 Park Ave., Suite 105 Rockville, MD 20850

Informed Consent
for Psycho-Educational and Psychological Services

Name of person receiving services:
Birth Date:

I hereby authorize, consent, and direct Lisa A. Lenhart, PhD to use procedures, methods, and materials that it deems prudent, reasonable, and appropriate to provide the requested psychological services.

I hereby release Lisa A. Lenhart, PhD from legal responsibility or liability for services provided. I also understand that I may withdraw this consent at any time with written notification to Lisa A. Lenhart, PhD.

I understand that payment for all services is my responsibility regardless of insurance coverage.

ACKNOWLEDGEMENT OF HIPAA PRIVACY NOTICE

By signing this form, you acknowledge that Lisa A. Lenhart, PhD has provided you access to a copy of the HIPAA Privacy Notice, which explains how your health information will be handled in various situations. By law, you are required to sign this form on your first date of service.

The Practice has provided me access to its Privacy Notice. I understand I may request a copy for my personal use.

I acknowledge that I have read, understand and agree to the above.
I understand and agree to the policies, procedures and fees related to the services that I have requested.

_____ _____
Signature of Person Receiving Services or Legal Representative Date

_____
Relationship to Person Receiving Services