Informed Consent for Psychotherapy Services

You have been provided with four documents (Notice of HIPPA Privacy Practices, FAQ and Consent for Telehealth Visits, Statement of Client Rights and Responsibilities and our Cancellation & No Show Policy) outlining your rights to privacy as well as our office policies. After reading them, we ask that print and sign your name along with today's date for each of the following statements.

A.
You have read the **Notice of HIPPA Privacy Practices** for Charles H Kuhn, LCSW, BCD and Karen Stickel, LCSW, BCD and are aware that you can request your own copy of said notice.

Your Name (Print)____

Your Signature______________________________________ Date _____/_____/_____

B.
By your signature, you attest that you have read and understand the **FAQ and Consent for Telehealth Visits** document and give your consent for treatment by way of telehealth services.

Your Name (Print)____

Your Signature______________________________________ Date _____/_____/_____

C.
By your signature you acknowledge that you have read and understand the **STATEMENT OF CLIENT RIGHTS AND RESPONSIBILITIES** and agree to abide by them.

Your Name (Print)____

Your Signature______________________________________ Date _____/_____/_____

D.
By your signature, you acknowledge that you have read, understand and agree to the **CANCELLATION & NO SHOW POLICY.**

Your Name (Print)____

Your Signature______________________________________ Date _____/_____/_____