THERAPIST-CLIENT SERVICES AGREEMENT
CATHERINE M. LESLIE, PH.D., PLLC
Signature Page

I. ***(This must be signed prior to your first session.)***
I have received a copy of the Catherine M. Leslie, Ph.D., PLLC. THERAPIST-CLIENT SERVICES AGREEMENT and a copy of the Catherine M. Leslie, Ph.D., PLLC. PRIVACY NOTICE

_____ _____
Name (Patient Representative) Date

_____
(Relationship to Client)

II. ***(This must be signed prior to your first session.)***
I have read, understand, and accept the following by initialing each item:

____ that Catherine M. Leslie, Ph.D., Inc. may disclose Protected Health Information as necessary to my insurance company if I want my insurance to be filed. If this is not initialed, I understand that I must pay in full for my services.

____ that Catherine M. Leslie, Ph.D., Inc. may use Protected Health Information within the practice for the purpose of Treatment/Consultation

____ that Catherine M. Leslie, Ph.D., Inc. may share Information as necessary with my primary care physician. If you do not wish information to be shared with your physician initial the "no" block below.

____ NO, do not share information with my physician

Please initial the following if your therapist or the Catherine M. Leslie, Ph.D. staff:

____ may contact you or leave messages at your **home** telephone number

____ may contact you or leave messages at your **work** telephone number

____ may contact you or leave messages at your **cell** phone number

____ may contact you by **e-mail**

I have read, understand, and accept all of the provisions of the Catherine M. Leslie, Ph.D., PLLC
THERAPIST-CLIENT SERVICES AGREEMENT and the Catherine M. Leslie, Ph.D., PLLC. PRIVACY NOTICE

_____ _____
Name (Patient or Representative) Date

_____
Relationship to Client