Hannah Bookbinder, LSW, MEd

1 Bala Avenue, Suite 125
Bala Cynwyd, PA 19004

1137 Lancaster Avenue
Berwyn, PA 19312

610 647-3959 ext. 107
Hannah@Academic-Ally.com

Consent to Evaluation, Consultation, Treatment

I/we acknowledge receipt of a copy of the contract for services and business practices. It has been reviewed with me/us and I/we have been afforded the opportunity to have my/our questions answered. I/we understand that no guarantees or assurances have been made as to the outcomes that may result from my/our working with AcademicAlly, LLC. I/we hereby consent to evaluation, consultation, and/or treatment/ I/we understand the fee schedule and agree to be responsible for all charges incurred during the course of services received.

____
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____
Client (14 years or older) or Parent

____
Parent

____
Parent

Consent to Obtain/Release Information

In order to help my child or myself, I (parent/client's name) _________________________, give AcademicAlly, LLC consent to obtain/release information to the following parties (please list names of individuals we can speak with on your behalf:

____
____
____
____
____

Parent/Client's Signature:____ Date:______________

Therapist's Signature:____ Date:______________

Acknowledgment of Receipt of HIPAA Rights

Patient/Client Name:____
DOB**:** ____
I hereby acknowledge that I have received and have been given an opportunity to read a copy of AcademicAlly, LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact AcademicAlly, LLC at 610 647-3959 ext. 107.

Signature of Patient/Client **Date**

____

Signature or Parent, Guardian or Personal Representative * **Date**

____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____
Signature of Staff Member **Date**