INSTITUTE FOR STRESS CONTROL
501 W OGDEN AVENUE, SUITE 6
HINSDALE, IL 60521
630.920.0900

PATIENT AGREEMENTS AND AUTHORIZATIONS

Consent for Treatment

I consent to the treatment provided by the Institute for Stress Control and its employees and designees. I authorize the mental health care services determined to be necessary or advisable to address my needs.

Authorization for Release of Personal Health Information

I understand that my Personal Health information (e.g., diagnosis, date of onset of difficulty, treatment plan, projected number of sessions, etc.) cannot be disclosed to my insurance carrier without my prior consent. I understand that I will be told in advance the diagnosis to be provided to my carrier. Because treatment plans requested by carriers emphasize what the therapist must do in the course or treatment, the Practice has not routinely shared treatment plans with patients. However, I understand that I am entitled to know the treatment plan used in my care and that the information will be disclosed to me at my request. I understand that I will not be asked for consent should the practice be asked by the carrier to disclose information that *has already been disclosed* (e.g., date of service, the address of the office). I understand that I may not receive insurance reimbursement if I do not consent to the release of requested information.

Assignment of Insurance Benefits/Payment Guarantee/Collection Fee

In the case that I do not pay for each session at the time of service, I authorize payment to be made directly to the Practice for insurance benefits payable to me. I understand that I am financially responsible to the Practice for all services rendered whether or not those services are covered by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney fees. I also understand that the only information to be disclosed to the collection agency will be that which is necessary to facilitate the collections process.

Privacy Policy

I acknowledge having received the Institute for Stress Control's **Notice of Privacy Practices**. My rights (including the right to see and copy my record, to limit release of my health information, and to request a change in my record) are explained in the **Privacy Practices**. I understand that I may revoke my consent for release of my health care information, except to the extent the Practice has made disclosures with my prior consent. In order to revoke my consent, I must notify the Practice by sending a written revocation to the Institute for Stress Control.

______________________________	______________________________	
Name of Patient	Signature of Patient (required if patient is 12 years or older)	
______________________________	______________________	____________
Signature of Patient or Authorized Person	Relationship	Date
______________________________	__________________	
Signature of Witness	Date	