Stefanie Maxwell, Psy.D.., P.C.

4305 N. Lincoln Ave., Office J

Chicago, IL 60618

Consent to Treatment

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be charged for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

Stefanie Maxwell, Psy.D.

❑ Copy accepted by client ❑ Copy kept by therapist

Assignment of Benefits

I hereby authorize the release of any medical or other information necessary to process claims submitted and conduct reviews, quality assurance, and post-payment medical reviews on my behalf to Medicare or other commercial insurance for the services provided to me. I further authorize payment of medical benefits for the services provided directly to Stefanie Maxwell, Psy.D., P.C. I understand that Stefanie Maxwell, Psy.D., P.C. protects my personal health information in accordance with HIPPA guidelines and standards.

_____ _____

Signature of client (or person acting for client) Date