Park Ridge Psychological Services
542 Busse Hwy.
Park Ridge, IL 60068

INFORMED CONSENT FOR TREATMENT

This form acknowledges that you have requested professional services and sets forth the agreement concerning our understanding of such services.

1. I understand that these services involve evaluation/therapy, and whatever services are provided will be by mutual agreement between I and _____.
2. By participating in services recommended by my therapist, I agree to pay for these professional services according to the fee schedule we have discussed.
3. I agree to pay in full all fees for services provided and I understand and agree that I am responsible for any charges that are not covered by insurance or any other third-party payor. I also agree to assist PRPS in submitting claims for insurance reimbursement.
4. I hereby request that payment of insurance benefits be made directly to PRPS. I authorize PRPS to release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement. This agreement covers the entire period of my relationship with PRPS.
5. I understand that I will be charged on the basis of expended time and that my therapist reserves the right to terminate the relationship for non-payment. Any payments received from third parties (i.e., insurance) will be credited to my account; however, I am primarily responsible for payment of any outstanding balances. A credit card is required to be on file.
6. I acknowledge that any missed sessions will be charged the full fee on the credit card unless you call within 24 hours. Balances that go beyond 2 months will be charged in full to the credit card.
7. Returned checks: a $20 service charge will be applied for checks returned by my bank for any reason. If two or more checks are returned, checks will no longer be accepted.
8. I understand that payment plans can be arranged, at my request.
9. In the event if becomes necessary to use the courts to collect any unpaid balance, I agree to pay reasonable attorney fees and any and all court costs which may be incurred.

Please sign this agreement so we have a mutual memorandum of our understanding. You may have a copy of this for your records.

/ /2019

Patient or Guardian Signature Date