Decatur Psychological Associates, P.C.
3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
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www.decaturpsych.com

Consents

*Patient's Full Name*_____ *Date of Birth*_____

CONSENT OF TREATMENT: I authorize and consent to the performance of psychiatric treatment and/or testing considered necessary or advisable by staff associated with Decatur Psychological Associates, P.C.

ASSIGNMENT OF BENEFITS: I hereby authorize direct payment of mental health benefits to Decatur Psychological Associates, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I also understand that if this bill goes to collection and/or an attorney, I am fully responsible for all reasonable costs for collection and/or attorney fees that are incurred, as well as court costs.

RELEASE OF INFORMATION: I authorize Decatur Psychological Associates, P.C. to release information including but not limited to; Medical History, Diagnosis, Mental Health Assessments and **Progress Notes** to any physician that may have referred me to this practice or to any physician that I may be referred to by this practice.

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Signature of Patient (or Guardian) Initials Date Signature of Guarantor Initials Date

CONSENT FOR USE OF PROTECTED HEALTH INFORMTION (PHI) FOR TREATMENT, AND PAYMENT AND HEALTHCARE OPERATIONS: My "PHI" means health information, including my demographic information, collected from me and created or received by my health care provider, another health care provider, a health plan, my employer or a health care clearinghouse. This "PHI" relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use of disclosure of my "PHI" for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my "PHI" is used or disclosed to carry out treatment, payment or healthcare operations of the practice. My Provider is not required to agree to the restrictions that I may request. However, if she/he agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that my provider has taken action in reliance on this consent. I understand I have the right to review my provider's Notice of Privacy Practices prior to signing this document.

× _____ _____ _____

Signature of Patient (or Guardian) Initials Date