500 W. Central Rd.
Suite 200
Mt. Prospect, IL 60056
(708) 789-5669

CONSENT FOR SERVICE AGREEMENT

Client Name: _____ Insured Name: _____

AGREEMENT TO OFFICE & BILLING POLICIES

I agree to make payment and/or co-payment at the time of service.

I understand that telephone consultations of 15-30 minutes will be charged for a half-hour session. Consultations of 31-60 minutes will be charged for one-hour sessions.

I understand that cancellations of appointments must be made at least 24 hours prior to the appointment time or I will be charge for the visit.

Signed: _____ Date: _____

AGREEMENT OF BENEFITS

I hereby authorize and request that my insurance benefits be paid directly to the Provider/Agency. I understand that I am financially responsible for non-covered services.

Signed: _____ Date: _____

AGREEMENT FOR FINANCIAL REPAYMENT:

I agree to pay $_____ each week after my services are terminated and until all payments are met for services rendered.

_____ Date: _____