

Affirming Alternatives Psychological Services, P.C.
Dr. Kathleen Young, Psy.D., Licensed Clinical Psychologist
1348 West Glenlake Avenue
Chicago, Illinois 60660
773-381-1922

Informed Consent for Participation in Treatment

Name: _____ Phone: _____

DOB: _____ SSN: _____

Please read this consent form carefully, as it describes the policies and procedures followed by your psychologist. You will receive a copy of this form.

Types of Service Provided by Your Psychologist:

You will be interviewed and may be asked to fill out some questionnaires to assist the psychologist in determining how best to help you. Treatment usually involves individual meetings with the therapist, but may also include group treatment and/or involving family members or significant others in some individual sessions. All treatment will be conducted only with your consent.

What You Can Expect from Treatment:

The duration of treatment is different for each person and can be difficult to estimate; your therapist will address any concerns that you have about this. If you are not feeling satisfied with your treatment for any reason, you are asked to discuss this directly with your therapist. The therapist will work with you to uncover what might be preventing progress, will modify goals with you if appropriate, and will make a referral for you to (an)other professional(s) if necessary, and/or at your request. Sometimes people find that they have a temporary increase in their level of distress when beginning psychotherapy, because the process of working on personal issues can be difficult; please be aware of this.

Confidentiality:

What you discuss with your psychologist is kept confidential, or private, with some exceptions. The **Notice of Privacy Practices** provides detailed information about how private information about your health care is protected and under what circumstances it may be shared.

Fees for Services:

Payments for services must be made at the time of each session. If you use insurance to pay for treatment, you are expected to pay any co-payment at the time of service. Should your insurance company refuse to remit payment for the services, you will be held responsible for paying the amount in full, as allowable by contract. If you do not pay your bill within 30 days of the date of an invoice, 2% interest may be added per month to the balance; in addition, if you default on your bill you may be held responsible for collection charges and/or attorneys' fees. The following fees are charged for services(reduced fees may be arranged in advance):

Initial Assessment Session = \$165.

Therapy Session (45 minutes) = \$150. Therapy Session (30 minutes) = \$75.

My reduced fee: _____

Cancellation policy:

You will be billed at your full fee rate if you miss an appointment without providing at least 24 hours notice. (Insurance will not be billed; this is charged to you.)

Please initial one of the lines below and then sign to indicate that you have read and understand: 1) this Informed Consent form for participation in treatment, 2) the Notice of Privacy Practices form and how information about you may be used or disclosed, and 3) that you consent to treatment and the provisions in the *Informed Consent and Notice of Privacy Practices* form.

_____ I authorize my psychologist to release information about me as necessary to my insurance company for billing purposes and to receive payment directly from my insurance company. I understand that I am responsible for payment of any balance or co-pay not covered by my insurance.

_____ I do NOT authorize release of any information about me or my treatment to an insurance company. I will be responsible to pay all fees for treatment myself.

Signature and Date

Signature of Parent /Legal Guardian Date Signature of Second Parent/Guardian and Date

Printed names of Parents or Legal Guardians or Personal Representatives (if applicable)