Journey Well Now

B. Ronni Greenberg, Psy.D., PC

3748 N. Ashland Avenue, 1-N, Chicago, IL 60613
773/405-6007

CONSENT TO TREATMENT:

Please read the following policies and initial your consent and acknowledgement of these policies.

I hereby consent to the treatment provided by B. Ronni Greenberg, Psy.D., PC and its employees or designees. I understand that no promises have been made to me as to the results of the treatment or any procedures provided by this therapist. **(____)**

I am aware that I may stop my treatment with this therapist at any time. Should I elect to stop treatment, I will still be responsible for paying for the services which 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.) **(____)**

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

I authorize use and disclosure of personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the Practice. I authorize B. Ronni Greenberg, Psy. D., PC to release any information required in the process of application for financial coverage for the services rendered. This authorization provides that B. Ronni Greenberg, Psy. D., PC may release objective clinical information related to my diagnoses and treatment, which may be required by my insurance company or it designated agent. **(____)**

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/ COLLECTION FEE:

I authorize payment to be made directly to the B. Ronni Greenberg, Psy. D., PC for insurance benefits payable to me. I understand that I am financially responsible to B. Ronni Greenberg, Psy. D., PC for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorneys' fees. **(____)**

CANCELLATION POLICY:

I agree to reschedule or cancel any and all appointments by contacting the provider's office telephone number/voicemail. Any cancellation made via email, text, fax, etc. will not be considered as a viable contact with the provider. **(____)**

PRIVACY POLICY:

I acknowledge having been offered the Provider's ″Notice of Privacy Practices″. My rights including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, is explained in the Policy. I understand that I may revoke in writing my consent for release of my health care informaation, except to the extent that my therapist has already made disclosures with my prior consent. **(____)**

B. Ronni Greenberg, Psy.D, PC, is not affiliated with the other practitioners in Suite 1-N unless explicitly stated. Shared space does not impy a referral relationship

Client Signature: _____Date: _____

I, the therapist, have discussed the issues above with the client (and/or his/her parent, guardian or 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: _____