PATIENT'S NAME: _____

_____ Initial Here

I understand that I am responsible for my fee, payment and/or co-insurance. I agree to be responsible for the full payment of fees for services rendered. Finding Balance, Ltd. will submit claims for services rendered to my insurance company and will honor contractual agreements made with those managed care companies which stipulate reimbursement restrictions.

_____ Initial Here

I hereby consent to treatment by clinicians at Finding Balance, Ltd. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

_____ Initial Here

I authorize the release of necessary medical information for insurance reimbursement purposes.

_____ Initial Here

I authorize the payment of medical benefits to the provider of services.

Finding Balance, Ltd. is a group practice that is owned and operated by Reem K. Cutinello, a clinical social worker who is licensed by the state of Illinois to practice social work. In addition to Reem Cutinello, the practice consists of professional counselors, social workers and student therapists who work under the direct supervision of Reem K. Cutinello, LCSW. In order to provide you the best possible care, therapists may share information regarding your case with Reem K. Cutinello as they seek consultation and supervision with her regularly. You have a right to and are encouraged to contact Reem K. Cutinello directly at any time regarding your care in this practice. All therapists at Finding Balance, Ltd. are mandated reporters in Illinois. They are required by law to report any suspected child abuse or neglect. They are also required to make a report of a patient is a lethal danger to him or herself or to others.

To provide effective assessment and treatment, your therapist will ask personal questions. Excluding the aforementioned circumstances, all personal information is kept strictly confidential. No information about you or your case will be released to anyone outside of the practice of Finding Balance, Ltd. without your written authorization and consent.

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other providers or individuals can be made by Finding Balance, Ltd. only by my signed or verbal consent.

_____ _____

Patient or Guardian Signature(s) **Date**