Patient Name:_____ Date of Birth:_____

Palos Behavioral Health Professionals
11800 S. 75th Ave, Third Floor
Palos Heights, IL 60463
Phone: 708-671-8440 Fax: 708-671-8446

Acknowledgment of Agreement

I have received, read and understood the Palos Behavioral Health Professionals' **Outpatient Services Agreement.**

_____	_____	_____
Patient Signature (age 12yrs. & older must sign)	Print Name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date
_____	_____	_____
Witness Signature	Print Name	Date

I have received, read and understood the **Policies and Practices to Protect the Privacy of Your Health Information Notice (HIPAA).**

_____	_____	_____
Patient Signature (age 12yrs. & older must sign)	Print Name	Date
_____	_____	_____
Parent/Guardian Signature	Print Name	Date
_____	_____	_____
Witness Signature	Print Name	Date

Any questions I may have with regards to the Agreement have been explained and discussed with my provider.
I have also been advised the provider has offered no guarantee as to the success, or as to a specific outcome, of treatment. Fully understanding the above information, it is my intention to proceed with and/or continue my treatment with the designated PBHP provider at this time. _____.
Initial.

Assignment and Release to Insurance

I, undersigned, certify that I (or my dependent) have insurance coverage with (_____) and assign directly
Name of Insurance Company
to Palos Behavioral Health Professionals, all benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____		_____	
Patient Signature	Date	Responsible Party	Date

I understand that if I cancel a scheduled appointment I need to give notice at least 24 hour prior to the appointment or I will be charged the full fee, which is not billable to insurance. Note. The Outpatient Service Agreement describes this fee. _____.
Initial

Parent/Guardianship

I understand, there are no restrictions to providing, when necessary, information regarding appointments, medication management and billing information to biological parents and/or legal guardians of children under the age of 18. If there is a signed court order stating no communication should take place with an individual, upon receipt of that document we will be able to comply with that request. If there are people who you would like to have non-clinical information shared a release of information from the front desk is required.

_____
Parent/Guardian Signature

Dr. Christopher Higgins, Psy.D. is the Sole Proprietor of Palos Behavioral Health Professionals. Any questions or concerns regarding privacy rights or the services of Palos Behavioral Health Professionals should be directed to him at 708-671-8440.