Center for Conscious Counseling
Dr. Ralph Whetstine, Psy.D. & Associates, P.C.

Dr Ralph Whetstine, Psy.D.
830 E. Higgins Rd, Suite 104H
Schaumburg, IL 60173
(708) 825-6108

Dawn Whetstine, LCSW
850 E. Higgins Rd, Suite 125P
Schaumburg, IL 60173
(708) 825 6037

Consent for Treatment and Service Agreements

________ Initial
________ Date

1. CONSENT TO TREAT: For myself, or as a legal guardian of a minor, I hereby voluntarily and knowingly agree and do give my express consent to Dr. Ralph Whetstine, Psy.D. & Associates, PC dba Center for Conscious Counseling to receive psychotherapeutic treatment. I am aware that the practice of psychotherapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of any diagnosis or treatment, or examination or treatment performed. I declare that I have provided or will provide financial, family, and medical information as needed and requested to the best of my knowledge, and believe that such information already given is true, correct, and complete.

________ Initial
________ Date

2. ASSIGNMENTS OF BENEFITS AND RELEASE OF MEDICAL INFORMATION: I hereby authorize assignment of benefits from my insurance company to Dr. Ralph Whetstine, Psy.D. & Associates, P.C. dba Center for Conscious and give permission to release medical information to process all insurance claims on my behalf. When possible, I agree that the insurance benefits be paid directly to Dr. Whetstine/CFCC. <u>I understand that I am financially responsible for noncovered services determined by my plan. I acknowledge that a quote of my benefits from Dr. Whetstine/CFCC is only an estimate of what my portion may be</u>. I understand that my insurance company's explanation of benefits/statement will be the final determination of my responsibility when processed correctly.

________ Initial
________ Date

3. AGREEMENT FOR FINANCIAL REPAYMENT AFTER COMPLETION OF SERVICES: In the event I have an outstanding balance after I discontinue services I agree to pay-off my balance in full or contact Dr Whetstine/CFCC and make payment arrangements. I realize that a delinquent account over 60 days will be subject to a collection agency.

________ Initial
________ Date

4. ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY: I have received a copy of the HIPPA Notice of Privacy Practices of Dr. Ralph Whetstine, PsyD. And Assoc, dba Center for Conscious Counseling. I have received, read, or have had read to me, and understand the HIPPA policy and have had the opportunity to ask questions about it. I understand my rights to privacy, the expectations to my rights to privacy, and my rights to access my records.

________ Initial
________ Date

5. CONSENT FOR COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI): I understand non-encrypted email/ text messaging may put PHI at risk, I am granting consent for communication regarding appointments, clinical documentation and/or financial statements through a non-secured electronic correspondence.

________ Initial
________ Date

6. REVOKING CONSENT: This consent may be revoked in writing by me at any time, except to the extent of actions that have already been taken in reliance on the consent given.

Patient Name (Please Print)	Signature of patient (12 years +)	Date
Parent/Guardian (Print)	Signature of Parent/guardian	Date
Witness (relationship)	Signature of Witness	Date