CATHERINE J. HUNTER & ASSOCIATES
Catherine Hunter &
Assoc. 765 Ela Road, Ste
211 Lake Zurich, IL 60047
847-550-0395

# INFORMED CONSENT FOR OUTPATIENT TREATMENT

I voluntarily consent to outpatient treatment/assessment by Catherine J. Hunter, LCSW, & Associates. I am aware that my therapist believes and has explained to me that this treatment will likely benefit me. I understand that no guarantees have been made to me as to the results of the treatment.

I understand that it is my responsibility to inform my therapist of any changes in my physical or mental conditin, any medication changes I may make and any changes in my eligibility for insurance benefits if I am seeking to utilize same benefits.

I acknowledge full responsibility for payment of mental health services rendered at the time of service.

I understand I have the right to terminate my treatment with my therapist at any time I choose to do so, and that while I will incur no further costs that I will remain responsible for payment of services previously rendered.

I authorize Catherine J. Hunter & Associates to acknowledge my first appointment to my referral source, is appropriate.
All parties signing this document agree to keep confidential all statements made during treatment sessions/consultation as well as any and all records regarding the content of those sessions. It is agreee that this information will not be used as evidence in court without a prior written release from all parties to this agreement.

THE FOLLOWING IS ONLY APPLICABLE FOR SPECIALLY APPROVED CASES:

I authorize the release of any medical or other information necessary to process the claims made for mental health services rendered by Catherine J. Hunter & Associates. I also request payment of government or insurance benefits to be made directly to Catherine J. Hunter, LCSW, who accept assignments for services.

Signature of Client: _____ Date: ___/ /___

Signature of Client: _____ Date: ___/ /___

Therapist/witness: _____ Date: ___/ /___