Southern Illinois Associates, LLC
16 Junction Drive West, Ste 2 Glen Carbon, IL
Phone: 618-288-5019 Fax 618-288-5059

Authorizations and Agreements with Mr/ Mrs. _____.

Please read carefully and sign. The paragraphs below contain several agreements.

Authorization for Mental Health Services

I request treatment at Southern Illinois Associates, LLC. I consent to routine diagnostic evaluation, case management, and therapy and medication management as deemed medically necessary. I understand that Southern Illinois Associates, LLC makes no guarantees to me as to the results of the treatment or evaluation.

_____ _____

Patient's or Guardian's signature Date

Medical Insurance

I authorize the medical insurance company to pay directly for the above physician's services. However, I understand that both I and the person who signs below are responsible for all my fees, including any fees not paid by the insurance company.

_____ _____

Patient's or Guardian's signature Date

Release of Information

I authorize *Southern Illinois Associates, LLC* to release information about me to the medical insurance company and the referring physician. This authorization will end if I give written instructions to *Southern Illinois Associates, LLC* to that effect, which I may do at any time.

_____ _____

Patient's or Guardian's signature Date

Financial Responsibility

We, the undersigned, understand and agree that each of us is responsible for the patient's fees to Southern Illinois Associates, LLC, including any fees not paid by medical insurance; that if the account is not paid when due, reasonable collection and court costs will be paid by the undersigned; that we are responsible for full visits fees resulting from appointments not kept or canceled without a 24-hour notice; that fees for outpatient services must be paid at the time services are rendered; and that the we are or I am responsible for filing for insurance reimbursement.

_____ _____

Patient's or Guardian's Signature Date

I acknowledge that I have received the HIPPA Notice of Policies and Practices to Protect the Privacy of Protected Health Information

_____ _____

Patient's or Guardian's Signature Date