# INFORMED CONSENT FOR OUPATIENT TREATMENT

**ELIZABETH J KOWIESKI, LCPC**
**LICENSE NUMBER #180-001715**
**18 E DUNDEE RD, BLDG 2, UNIT 140 * BARRINGTON, IL 60010**
**PHONE: 630-853-9197/ EJKOWIESKI@GMAIL.COM**

I voluntarily consent to outpatient treatment/assessment by Elizabeth J Kowieski, LCPC. 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 change in my physical or mental conditions; any medication changes I may make and changes in my eligibility for insurance benefits if I am seeking to utilize same benefits. (Initial here____________)***

***I acknowledge Full Responsibility for Payment of Services Rendered at the time of Service by Elizabeth J Kowieski, LCPC. (Initial here___________)***

***I understand I have the right to terminate with my therapist at any time I choose to do so, and that while I will incur no further costs and that I remain responsible for payment of the services rendered up to and including date of termination. (Initial here __________)***

I authorize and deem appropriate that Elizabeth J Kowieski, LCPC, acknowledge my first appointment to my referral source. All parties signing this document agree to keep confidential all statements made during treatment sessions/consultations as well as any and all records regarding the content of those sessions; ***unless*** the client signs a **Release of Information Form** to authorize consultation with patient's General Practitioner, Psychiatrist, or other provider.

***It is agreed that this information will not be used as evidence in court without a prior written release from all parties, including Elizabeth J Kowieski, LCPC, to this agreement. (Initial here ___________)***

I hereby authorize the release of any medical or other information necessary to process the claims made for the services rendered by this therapist. I also request all payments for insurance benefits be made payable to Elizabeth J Kowieski, LCPC, who accepts assignments for services from said Insurance Agency.

Signature of Client: ____________________________________________Date ______________

Therapist Signature: ____________________________________________ Date ______________