Stephen C. Meyers, M.A., L.C.P.C.
Licensed Clinical Profession Counselor
636 Church Street, Suite 615 Evanston,
Illinois 60201
Phone (312) 925-8086

I have read the **Outpatient Services Agreement and HIPAA Notice** and discussed any questions I may have with my provider. *I understand that if I cancel a scheduled appointment I need to give 24 hours' notice, or I will be charged the full fee, which is not billable to insurance. Note: The Outpatient Service Agreement describes the 24 hour without notice fee.*

_____ _____
Patient Signature (age 12 and older must sign) Date

_____ _____
Parent/Guardian Date

Assignment and Release to Insurance (if applicable)

I, undersigned certify that I (or my dependent) have insurance coverage with

_____ and assign directly to Stephen Meyers all benefits, if
(Name of insurance company)

any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. Further, I hereby acknowledge and authorize Stephen Meyers and/or *Care Paths* to bill and/or release all appropriate information as may be necessary to process claims and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Patient Signature (age 12 and older must sign) Date

_____ _____
Parent/Guardian Date

Self-pay (if applicable)

I am aware of the cost of psychotherapy and/or services offered and aware that I am responsible for charges agreed upon. The cost for initial evaluation $_____, the cost for an individual therapy session $_____, the cost for group therapy session $_____, and the cost for family therapy session $_____.

_____	_____
Patient Signature (age 12 and older must sign)	Date
_____	_____
Parent/Guardian	Date