CHARLES E. BURDA, M.D. & ADVANCED BEHAVIORAL CENTERS OF DUPAGE

Terrace Executive Center
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Oakbrook Terrace, IL 60181
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Physicians: (630) 629-6550
FAX: (630) 629-6558

Hinsdale Professional Office Center
501 W. Ogden Ave., Suite 1
Hinsdale, IL 60521
Therapists: (630) 986-0599
Fax: (630) 986-1477

PATIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT. I am voluntarily requesting a diagnosis and treatment for a condition from which I am suffering. I understand my treatment may involve a referral for medication management, individual, family or group therapy, or hospitalization.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION.

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of the practice. I authorize Charles E. Burda, M.D. & Advanced Behavioral Centers of Dupage to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Charles E. Burda, M.D. & Advanced Behavioral Centers of Dupage may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE. I authorize payment to be made directly to Charles E. Burda, M.D. & Advanced Behavioral Centers of Dupage for insurance benefits payable to me. I understand that I am financially responsible to Charles E. Burda, M.D. & Advanced Behavioral Centers of Dupage for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

PRIVACY POLICY. I acknowledge having received the Disclosure and Informed Consent policies, describing my Right to Privacy; including the right to see and copy my record, to limit disclosure of my health information, and to request an amendment to my record, which is explained in the Disclosure. I understand that I may revoke, in writing, my consent for release of my health care information, except to the extent Charles E. Burda, M.D. & Advanced Behavioral Centers of Dupage has already made disclosures with my prior consent.

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Patient or Authorized Person Signature Relationship Date

_____

Child/Adolescent Signature Date

_____

Witness Signature Date