ALLIANCE CLINICAL
ASSOCIATES

Patient Agreement

7 Blanchard Circle – Suite 201 • Wheaton, IL 60189 • 630-653-2300

Hours and Cancellations

Each provider keeps his or her own schedule and will arrange appointments with you directly. Psychotherapy sessions with therapists are typically 45-55 minutes long. Most follow-up visits with physicians run 20-25 minutes.

Due to the policy of reserved appointment times, an appointment that you cannot keep must be canceled no less than 24 hours before the appointment time. Appointments that have not been canceled within 24 hours will be charged the regular session fee. Insurance companies will not pay for missed sessions, so payment for these will be your responsibility. Please note that we are not responsible to remind people of their upcoming appointments.

Emergencies

In case of an emergency, you may leave a message for your provider with our 24-hour answering service.

Phone Calls/Messages

Our general procedure is to leave our name and phone number when phone calls are returned. Please indicate your consent for our office to leave treatment information: appointment changes, medication changes, prescription information, account information, etc

☐ I authorize Alliance Clinical Associates to leave treatment information on my answering machine or voice mail at this number: ( )

Appointment Reminder: I request that Alliance Clinical Associates send me an appointment reminder via: (CHOOSE ONE):

☐ Home email address

☐ Work email address

☐ Text to cell ( ) -

☐ Phone call to ( ) -

Financial Policy

☐ I have received Alliance's financial policy and understand my responsibilities. If Alliance is submitting claims to my insurance company, I authorize them to receive payment of benefits directly. If Alliance is not contracted with my insurance, payment will be required at time of service and will be given a receipt with the necessary information for me to submit to my insurance company for reimbursement. I am responsible for all charges not paid by my insurance.

Prescription Refills

☐ I have received information on Alliance's prescription policy and understand my responsibilities. I authorize my physician to e-prescribe for me, and to view my prescription history electronically.

Confidentiality

☐ I acknowledge receipt of the Physician's Notice of Privacy Practices, detailing information about how the practice may use and disclose my confidential information. I understand that Alliance keeps an integrated medical record with full access to anyone at Alliance involved in my care.

☐ I hereby give my consent to Alliance (in accordance with HIPAA law) to use for the purpose of carrying out treatment, payment, or health care operations, any needed information contained in the patient record of:

(patient name)

This consent is valid until revoked by me.

Client Name Date

Client Signature Date