Linden Psychological Services
Paul Linden, Psy. D.

111 North Wabash Avenue
Suite 1806
Chicago Illinois 60602
(312) 499-6873

INDIVIDUAL THERAPY
INFORMED CONSENT

CONFIDENTIALITY

You have a right to expect that all communication between yourself and the therapist will be held private and confidential. No information can or will be shared about your participation in therapy or the content discussed in therapy except under the following conditions: 1) Clinical Psychologists are mandated reporters under the Illinois Child Abuse Prevention Act. If during the course of therapy you reveal information concerning the abuse of a child, this information must be shared with the Illinois Department of Children and Family Services. 2) If during the course of therapy you reveal information that leads the therapist to believe that you pose a credible risk of harm to another specific individual, the therapy may contact that individual in order to warn them of this potential harm. 3) If you engage in litigation in which you claim mental health as a component of your litigation, the therapist may be compelled by the court to release information as a matter of discovery. As the recipient of services, you may wave your rights to confidentiality by signing a release of information form.

HIPPA COMPLIANCE of DIGITAL RECORDS

This office does use Therapist Helper© for the management of digital records and VantageMed© for online billing. Both of these commercial software products are HIPPA compliant, and all digital records are encrypted and password protected.

CANCELATION POLICY

If you are unable to keep a scheduled appointment, you are to call the therapist 24 hours in advance of your appointment to cancel. If you fair to do so you may be charged for canceling or not showing for a session. Failed Appointments and Canceled Appointments cannot be billed to your insurance company. The fee for a canceled or failed appointment is $70.00.

AUTHORIZATION for INSURANCE

I authorize the release of any medical or other information necessary to process claims for insurance coverage. I also authorize the payment of medical benefits to Paul Linden, Psy.D. or Linden Psychological Services.

I _____ have read the above and have had any questions concerning this information answered to may satisfaction.

_____
Signed

_____/_____/_____
Dated