

**Park Ridge Psychological Services**  
36 Main Street, Ste. 106  
Park Ridge, IL 60068  
Phone: 847-692-6692  
Fax: 888-440-2577  
E-mail: [drpaterno@prpsych.com](mailto:drpaterno@prpsych.com)

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Address \_\_\_\_\_

**Fees: Individual Therapy:** \$135 per 45-50' session      **Initial Assessment/Interview:** \$200  
**Psychological Testing:** \$200 per clinical hour      **Group Psychotherapy:** \$60/hour

### INFORMED CONSENT TO TREATMENT AND/OR EVALUATION

I hereby authorize the psychological treatment and/or evaluation of myself (or the above named child) by Dr. Paterno. I have discussed stated goals of psychological treatment and/or evaluation and I understand that I have the right to ask my therapist information regarding diagnosis, goals for treatment, and estimated length of treatment.

I understand that personal notes taken by Dr. Paterno represent personal work product of my therapist and as such, remain her sole property. I understand and agree that Dr. Paterno may properly retain such documents in my file according to professional standards. He is not required to release personal notes about my care, since these represent work product, and are not part of the formal psychological record. Typewritten reports about my care can be sent out if I provide proper written authorization, and this will be done according to professional standards.

I have been informed of the procedure for reaching Dr. Paterno in the event of an emergency. I also understand the policy regarding cancellations and missed appointments. There will be no charge for cancelled or missed appointments if he is given at least 48 hours prior notice. However, a cancellation made less that 48 hours in advance will result in a \$50 fee, which must be paid before any further services are rendered. This fee will be charged directly to the client's credit card, if available.

I understand that this agreement becomes part of my psychological record which is accessible to the parties at will, but to no other person without written consent. Dr. Paterno will respect my right to maintain confidentiality of information communicated by me or obtained from me during the treatment period. I understand that there are legal limitations of such confidentiality (i.e., cases of suspected child or elder abuse, fear of danger to self or others, or in the event that information is ordered released by Court Order).

### FEE AGREEMENT

- I agree to pay in full all fees for services provided and I understand and agree that I am responsible for any charges that are not covered by insurance or any other third-party payor. I also agree to assist Dr. Paterno in submitting claims for insurance reimbursement.
- I hereby request that payment of insurance benefits be made directly to Dr. Paterno. I authorize him to release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement. This agreement covers the entire period of my relationship with Dr. Paterno.

Patient Signature (or Legal Guardian) \_\_\_\_\_ Date \_\_\_\_\_