Declination of Mental Health Benefit

I, _____, have been fully informed of my
[Print Complete Name]

insurance benefits eligibility by Northern Illinois Counseling Associates, P.C. (NICA), to have NICA bill Medicare and/or my insurance company for any and/or all mental health services rendered to either me and/or my family, by NICA, and at NICA's prevailing contracted rates, do hereby voluntarily and electively without advice and/or duress, direct NICA to bill me, in-full, and not to bill any third party payor, including Medicare and/or my insurance company, its third party agents, administrators, utilization reviewers and/or assigns, effective retroactive to the date of my first NICA rendered service and of a duration as to such time as any and/or all NICA rendered services are discontinued entirely.

Furthermore, I agree to pay all fees for services rendered at NICA's prevailing rates, out-of-pocket, and do hereby waive any and/or all mental health benefits (inclusive of psychotherapy, psychological testing, case management, etc.), under my health care plan for the duration of my insurance eligibility, retroactive to the date of the first NICA rendered service, and continuing through the present, and thereafter, unless otherwise specified, in writing, to NICA, Attention: Office Manager, via U.S. Postal Service mails (registered). It is understood that any written request for rescission of this document will apply to those NICA rendered services which are subsequent to but not prior to the date such rescission was postmarked by the U.S. Postal Service.

In so doing, it I my wish to deny Medicare and/or my insurance company (and/or any other insurance company), its third party payors and/or agents, its administrators, utilization reviewers and/or assigns, including my current employer and/or any other interested party(ies), from having access to my clinical file, in whole and/or in part, along with my diagnosis and/or acknowledgment of my receipt of, as well as my participation in any and/or all NICA rendered services, unless and/or until I give express written permission authorizing such disclosure consonant with the prevailing Illinois Department of Human Services Mental Health Code and/or Confidentiality Act.

I represent that I am duly authorized to execute this declination of mental health benefit, that I am of sound mind and body and that I have made this decision of my own free will, without force, duress, threat or advice.

By: _____ Date: _____
[Print Client Name]

By: _____ Date: _____
[Signature of Client, Parent or Responsible Party]

By: _____ Date: _____
[NICA Representative]