Taras W. Didenko, MD, PC & Associates
1827 Walden Office Square, Suite 510
Schaumburg, Illinois 60173
(847) 496-4525 (v) | (837) 660-2958 (f)

Information and Policies

****** Please Read Carefully ******

Welcome!

Thank you for selecting us for your mental and psychological needs. We are pleased to be of service to you and to assist you to reach your personal and clinical goals.

The following consent for treatment, information, and policies are an essential component of your successful therapy.

Consent for Treatment

Initials: _____

I give consent for treatment of (Patient's Name) _____ by any clinician associated with Taras W. Didenko, MD, PC, & Associates.

Behavioral Contract

Initials: _____

I, _____, promise to not take medications from my family members or any other medications that a doctor did not prescribe to me.

I promise to take all medications appropriately as directed by my psychiatrist, Dr. Taras W. Didenko.

I promise to see Dr. Taras W. Didenko every two to four weeks for follow-ups, upon the discretion of the doctor.

If I fail my obligations, stated above, Dr. Taras W. Didenko will dismiss me from his clinic and refer me to another psychiatrist.

Guarantee of Payment

Initials: _____

I understand that all charges for services rendered, including any copays and outstanding balances, are due at the time of service; unless the head psychiatrist, Dr. Taras W. Didenko, has approved other financial arrangements.

I understand that should the insurance company withhold or deny insurance benefits, which the guarantor is responsible for payment in full before the scheduled appointment.

I understand I must pay a $40.00 (forty dollar) fee for the completion of any requested disability insurance claims, and a $10.00 (ten dollar) charge for any required treatment notes.

We accept cash, checks, Discover®, MasterCard®, and Visa®.

Taras W. Didenko, MD, PC & Associates
1827 Walden Office Square, Suite 510
Schaumburg, Illinois 60173
(847) 496-4525 (v) | (837) 660-2958 (f)

PRIVACY NOTICE

The HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule provides federal protections for PHI (Protected Health Information) held by covered entities and gives patients an array of rights concerning that information.

At the same time, the Privacy Rule balances protection with the need to care for the patient so that it permits the disclosure of protected health information needed for patient care and other essential purposes.

Initials: _____

Taras W. Didenko, MD, PC, & Associates have offered me a written copy of their Notice of Privacy Practices. This notice provides in detail the uses and disclosures of my protected health information that this practice may use, my rights, how I may exercise my rights, and the clinic's legal duties concerning my protected health information.

RELEASE OF INFORMATION

I authorize the office of Taras W. Didenko, MD, PC, & Associates to release information on behalf of myself or my dependents to my insurance company or managed care organization to receive benefits and payments.

I authorize this release of information until resolution of the claim(s) related to this service.

I further expressly acknowledge that my signature on this document authorizes my clinician to release this information without any further signature from myself.

I give consent for release of information to my primary care doctor, policy holder's insurance payer, and managed care organization for continuity of care and billing purposes.

Initials: _____

This consent shall remain in effect for up to two years from the date of my last treatment unless I revoke this consent in writing.

Additional parties to whom Taras W. Didenko, MD, PC, & Associates may release information:

Name	Relationship	Phone
		(_____) _____-_____
		(_____) _____-_____
		(_____) _____-_____

Taras W. Didenko, MD, PC & Associates
1827 Walden Office Square, Suite 510
Schaumburg, Illinois 60173
(847) 496-4525 (v) | (837) 660-2958 (f)

Appointment Cancellation Policy

I understand that I must notify the office of Taras W. Didenko, MD, PC, & Associates about cancellations and rescheduling of an appointment at least **24 hours** before the scheduled appointment time.

Please call our office at (847) 496-4525, Monday to Friday between 9:00 am and 5:00 pm to cancel or reschedule an appointment.

Initials: _____ Failure to cancel or reschedule an appointment at least **24 hours** before the appointment will result in a $25.00 (twenty-five dollar) fee.

I understand that the cancellation of five consecutive appointments will result in denial of any further prescription refills and the patient may be referred out to another psychiatrist, upon the discretion of Taras W. Didenko, MD, PC, & Associates.

Refill Authorization

Initials: _____ I understand and acknowledge that due to Illinois State Regulations, the psychiatrists associated with the office of Taras W. Didenko, MD, PC, & Associates, are not allowed to authorize any prescription refills for a patient whom they have not seen for six to eight weeks.

I understand that it is my responsibility to schedule my appointment before my medications run out, keeping in mind that schedules fill up in quickly and that someone else may schedule your requested appointment date before you.

My signature, below, indicates my understanding and acknowledgment of all the above information and policies.

Print Name *(First MI Last)*: _____

Signature: _____

Today's Date *(mm/dd/yyyy)*: _____