



# Youth Services of Glenview/Northbrook

## Consent to Treatment

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Client Name:

Client Date of Birth:

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**Please read the following consent to treatment, initial to the left of each statement, and sign below:**

\_\_\_\_\_ I have received and read Youth Services' treatment agreement, discussed any questions or concerns with agency staff, and consent for the above-indicated client to receive clinical services from the agency, as outlined in the treatment agreement.

\_\_\_\_\_ I have received, read, and understand Youth Services' privacy practices, as outlined in the treatment agreement.

\_\_\_\_\_ If I am using my insurance, I authorize the release of information necessary for Youth Services to process the insurance claim for the above-indicated client's services and authorize payment of insurance benefits to Youth Services. Furthermore, I agree to pay the cost of what my insurance does not cover. If I am not using insurance, I consent to pay the agreed-upon private pay fee (as listed on the client information and billing form).

\_\_\_\_\_ I understand that payment for services are to be made at the time of service unless prior financial arrangements have been made.

\_\_\_\_\_ I understand that I am financially responsible for all scheduled appointments unless a minimum of 24 hours' notice is given and that Youth Services reserves the right to charge for missed sessions and late cancellations.

\_\_\_\_\_ I have disclosed all the above-indicated client's allergies, food restrictions, and/or medical restrictions. *Please list here:*

\_\_\_\_\_ I consent for the agency to provide emergency medical assistance to the above-indicated client, if necessary.

\_\_\_\_\_ I consent for agency staff or interns to transport the above-indicated client, if necessary and agreed upon with the client and parent/guardian.

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*Client or Parent/Guardian  
Signature*

*Client or Parent/Guardian  
Printed Name*

*Date of Signature*