



**ICCBT**

Indiana Center for Cognitive Behavior Therapy, PC

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FORT WAYNE, INDIANA 46825  
260-969-5583; FAX 260-969-5584  
[www.ICCBT.ORG](http://www.ICCBT.ORG)

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## TREATMENT AGREEMENT

I, \_\_\_\_\_, hereby request evaluation and treatment from the Indiana Center for Cognitive Behavior Therapy, PC (ICCBT).

I understand that medicine is not an exact science and that no guarantee can be made as to the success of treatment. I will insist on fully understanding the proposed treatment with its risks, benefits, and alternatives. I will unhesitatingly ask for a second opinion if I am in need of reassurance regarding the proposed plan of treatment. Once I agree to a plan of treatment, I will follow it to the best of my ability, and I will promptly notify ICCBT of any unexpected effects.

I have received the ICCBT Notice of Privacy Practices. I understand that the minimum necessary medical information about me will be disclosed by ICCBT for treatment, payment, and health care operations. I further understand that the ICCBT Notice of Privacy Practices may change, and that I may request a new copy of the Notice of Privacy Practices from ICCBT at any time.

I have received a schedule of professional fees from ICCBT, and in consideration of the services to be rendered to me, I agree to be responsible for prompt, full payment of all fees regardless of third party liability. I am responsible for interest on my account balance at the maximum statutory rate and any applicable service fee. In the event any balance is referred for collection, I am responsible for attorney fees and court costs as incurred.

If ICCBT does not accept my insurance, I understand that fees are due as stated and are payable at the beginning of the assessment or evaluation session (this allows ICCBT to focus entirely on my problems, needs and concerns during the session). If ICCBT does accept my insurance, I understand that I am responsible for paying my co-pay/co-insurance/deductible amount at the time the service is rendered.

I agree to accept financial responsibility for any missed appointment/"no-show" and my insurance company will not be billed for nor reimburse me for missed appointments. To avoid paying the full fee for assessment, 24 hours advance notice is required to cancel or reschedule an appointment without incurring this full fee charge to my credit/debit card. If you are more than 5 minutes late for a medication check, 10 minutes late for a half session or 15 minutes late for a full session you will need to reschedule the appointment and it is considered a late cancel.

Accounts which are not settled within a 45-day billing period will be charged a monthly service charge of 10%

ICCBT is hereby authorized to release any necessary confidential medical information to my insurance company for the purpose of obtaining reimbursement for services provided, and my insurance company is authorized to pay ICCBT directly for said services.

I agree that my failure to fulfill my obligations under this contract will immediately relieve ICCBT, its employees, officers, directors, and shareholders, of further obligations to me.

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Signature

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Date

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Witness

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Date