CAROL ELIAS, PH.D. **(909) 622-0148**
556 N. Diamond Bar Blvd., Ste. 103 8608 Utica Ave., Ste. 213
Diamond Bar, CA. 91765 Rancho Cucamonga, CA. 91730

CONSENT FOR TREATMENT

The undersigned patient or responsible relative or person hereby consent to authorize Carol Elias, Ph.D., to administer and perform any and all psychological examinations, treatments, and assessments which may occur during the course of the patient's care as either inpatient or outpatient. The undersigned also, agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Carol Elias, Ph.D. may disclose portions of the patient's records to any person or corporation which is or may be liable, for all or any portion of the charges incurred, including but not limited to insurance companies, health care service plans, or workers' compensation carriers. Special permission is needed to release this information.

The undersigned agrees, whether s/he signs as agent or as patient, that in consideration of the services to be rendered to the patient s/he hereby individually obligates him/herself to pay the full costs thereof, in accord with applicable laws, ordinances, resolutions, and orders of the insurance company. Such payment shall include the fees for professional services that are set by Carol Elias, Ph.D.

I request and authorize payment of any benefits be made on my behalf and agree to pay any remaining charges for which I am legally responsible.

The undersigned certifies that s/he has read the foregoing and is the patient, or duly authorized by or on behalf of the patient to execute the above and accept its terms. This agreement will remain in effect until revoked by me in writing. A photocopy of this form is to be considered as valid as the original.

____
PATIENT OR RESPONSIBLE PERSON **PRINTED NAME**

____
PATIENT OR RESPONSIBLE PERSON **SIGNATURE**

____
RELATIONSHIP TO PATIENT IF NOT SELF

____
DATE