



Rev. C. Scot Giles, D.Min., LLC
Specializing in Issues of Health and Well-Being

STATEMENT OF INFORMED CONSENT

Welcome and Introduction

On behalf of Adventist LaGrange Hospital and Rev. C. Scot Giles, D.Min., LLC, we welcome you to our I CAN program. I CAN is a physician prescribed support group based on the Exceptional Cancer Patients (ECaP) model of psychotherapy, developed by Bernie Siegel, M.D.

The I CAN group uses supportive and exploratory verbal techniques, guided imagery, hypnotism and various mental exercises and experiences. Other than the intake interview, all sessions are at Adventist LaGrange Memorial Hospital in a group setting. Individual consultation may be available to group members on request. However, such consultation is not part of the I CAN program.

Goals

The primary goal of an ECaP-oriented group is to assist persons with life-changing illness to use the time of medical treatment and recovery as a time of self-improvement. The techniques used are intended to aid you in controlling discomfort and to improve your mood and lifestyle. There is also some evidence that participation in a group of this sort may help you medically. However, we cannot promise either short-term or long-term medical or mental health improvement using these, or any, techniques.

Meetings

The I CAN group meets at Adventist LaGrange Memorial Hospital, 5101 South Willow Springs Road, LaGrange, Illinois on Mondays from 7:00 pm to 9:00 pm. The group will meet every week, unless unforeseen circumstances arise which preclude the meeting. In such cases we will attempt to inform you of the cancellation.

Fees

As the I CAN group is therapy there is a fee charged for the program. Your health insurance policy may pay part of the costs of your participation in the I CAN program. However, we do not recommend that you assume this. Most participants pay for the program privately.

Release of Information

By signing this document below, you authorize Rev. C. Scot Giles, D.Min., LLC, Adventist LaGrange Hospital, or any agent they may assign, to release to your prescribing physician, insurance company, any legally required reporting agency, any psychiatric physician or counseling supervisor, any medical or personal information they may have regarding you. It is our explicit intent to release information to your prescribing physician.

Signed: _____

Please Print Your Name: _____

Date: _____