CONSENT FOR SERVICES
AND
ACKNOWLEDGEMENT OF FINANCIAL OBLIGATIONS

CONSENT FOR TREATMENT:

_____ hereinafter "Practice", provides evaluation, assessment, and psychotherapy to individuals. The Practice will generally develop a comprehensive treatment plan which will be modified regularly depending on the needs and progress of services provided. Should a higher level of care be indicated, the Practice will work with you to achieve the most appropriate level of care and, if appropriate, refer you to a therapist, agency or facility that is able to provide you with a level of service appropriate to your needs.

Often the therapy process results in experiencing intense emotional response and processing life experiences which may evoke positive or negative feelings. There is no way to estimate the duration of or quantify results as the therapeutic process is dynamic and unique to the issues, needs, and types of treatment that is most effective to each individual. Therapy, by its nature, requires continuous adjustments to the treatment plan and modalities of treatment. There is a small risk that your condition may worsen during treatment. If at any point you are unhappy about the progress, process, or outcome of your treatment, please discuss this with your therapist so that, together, attempts can be made to resolve any difficulties and/or arrive at a treatment plan that better meets your needs.

By signing at the bottom of this document you consent to participate in mental health services/therapy. You also acknowledge that patients who participate in mental health services must explore and analyze many personal, family, friendships and other interpersonal experiences and behaviors, both good and bad. Therapy will often assist in improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy requires commitment, effort, and consistent participation on your part to secure the best results. Successful therapy requires your involvement in the process and is most successful if you commit to being honest with your feelings and being willing to thoughts, feelings and/or behaviors.

Successful therapy is not a one-size-fits-all proposition. Often various treatment options such as various individual psychotherapy, group, couple, family or self-help therapies, and/or, in certain circumstances the referral to an MD for the evaluation and/or management of medication may be helpful. It is not unusual for a therapist to recommend or refer you to seek other treatment options.

TELEMENTAL HEALTH:

I further hereby consent to participate in telemental health as part of my services, if applicable. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2) I understand that there are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3) I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that the privacy laws that protect the confidentiality of my protected health information ("PHI") also apply to telemental health unless an exception to confidentiality applies.
5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call your therapist at _____ to discuss since we may have to re-schedule.

EMERGENCY PROTOCOLS:

You agree to provide your location in case of an emergency to your therapist. You agree to inform your therapist of the address where you are at the beginning of each session. Your therapist will require that an emergency contact person may be contacted in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

CONFIDENTIALITY:

The confidentiality of communication between a client and a therapist is very important and is protected by the ethical practices of the therapist as well as State and Federal Law. The Practice will make every effort to keep information regarding your evaluation, diagnosis, and treatment strictly confidential. A consent for release of information must be reviewed and signed by you in order for oral, written or electronic information about you to be released by the Practice to any other person or agency absent emergent circumstances.

All records or communications related to therapy are confidential and my confidences shall be maintained except as required by law, including, HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act. These confidentiality laws and regulations do have exceptions which allow, and under certain circumstances, mandate that a therapist divulge information which is necessary to protect from imminent harm, emergency situations, child and elder abuse and the like. If you become involved in certain types of court proceedings wherein you have placed your mental health into issue in your claims or defenses, your records and information may be subject to disclosure in such a case.

SESSIONS/CANCELLATION POLICY:

Therapy sessions are generally between 45 to 60 minutes long, although the precise length may vary. Please arrive on time as you use your own time when you arrive late for an appointment, if you are late your appointment time will not be extended. The number and frequency of sessions are determined based

on what is clinically necessary and may be affected by insurance coverage, client and therapist availability, and the like. Regular and consistent sessions are necessary for effective therapy.

Any cancellation or rescheduling of an appointment must be done at least 24 hours prior to your appointment by calling and leaving a voice mail message with the office. Failure to cancel with at least 24 hours' notice will require that you pay the full fee for the missed session personally. It is important for you to understand that your therapist has set aside your appointment time for you and cannot simply do other work if you are unable to attend. Fees for missed sessions are never paid by insurance companies and therefore you will be responsible for the payment for any missed appointments.

FEES:

The Practice is committed to the successful treatment of your condition. Please understand that payment of your bill is considered part of your treatment. Your clear understanding of the financial and practice policies is important to the professional relationship. Please discuss with the Practice directly if you have any questions regarding this.

A. Private pay/non-insured patients are charged at a rate of $_____ for the initial 60-minute session;
B. Private pay/non-insured patients are charged at a rate of $_____ for subsequent 50-minute sessions.

If you are covered by an insurance company with whom the practice is an in-network provider, the Practice must comply with and accept payment pursuant to the contract that both they and you have with the insurance company. The rates for in-network insurance companies may not be negotiated, they are fixed by contract. You are responsible, by law, for any co-payments or deductibles associated with your insurance coverage for services that are covered by your policy. There are certain services that the Practice provides that are not covered by insurance companies, including, but not limited to, telephone conversations/sessions, video conferences, site visits, report writing and reading, drafting of summaries, consultations with other professionals, expenses related to any legal process (including attorney's fees) in our efforts to comply with state and federal confidentiality requirements as well as the therapist's time (portal to portal) or if a therapist is obligated to attend depositions or trial. If any of these uncovered services or expenses are provided or incurred, you will be charged at the private pay/non-insured patients hourly rate unless other arrangements have been made and agreed to and you agree that you will be obligated and will pay any such charges.

Please note that phone communication is not covered under telehealth by your insurance plan:

> If you have a telephone conversation with the Practice that extends beyond 10 minutes you will be personally responsible to pay at a rate equal to your ordinary office/telehealth hourly fee prorated for the duration of the call.

If you think you may have trouble paying your bill on time, please discuss this with your therapist so a solution can be attempted.

PAYMENTS AND INSURANCE:

If your therapist is not an in-network provider for your insurance, you will be expected to pay the entire session fee, for each session at the time of the session.

If the Practice is an in-network provider of your insurance network, then the Practice is happy to bill your insurance company directly as a convenience offered to you. You must keep the Practice informed immediately regarding any changes to your insurance if the Practice is billing to your plan on your behalf. You will be responsible for the payment of any co-payments or deductibles associated with your policy at the time of the session as well as any uncovered services as identified above. Merely because an insurance company authorizes services, they often do not guarantee payment and you will be ultimately responsible for the cost of services provided which are not reimbursed by insurance providers for whatever reason they are not covered. You (not your insurance company) are responsible for full payment of fees, so, it is important to confirm exactly what mental health services your insurance policy covers. If you must obtain authorization from your primary care physician or your insurance company prior to treatment or office visit it is your obligation unless agreed upon to the contrary. Any secondary insurance claim filing is your responsibility.

If you have health insurance, but your therapist is an out-of-network provider, you must pay the full private pay rate and the Practice will provide you with a bill suitable to present to your insurance company to secure any out-of-network reimbursement your plan provides.

Failure to keep payments current may result in termination of services. If payment is not received from the insurance carrier or any other responsible third party within 90 days, the outstanding balance will be transferred and billed to you directly.

If you do not have insurance or the Practice is not in your insurance network, and/or you do not have your insurance card, then full payment is due at the time of service. The Practice accepts payment in the form of cash, check, VISA, or Mastercard.

Twenty-four (24) hours minimum notice is required for a cancellation of a reserved session time, or YOU WILL BE CHARGED the full session fee of $170.00. Please be aware that your insurance will not accept claims for cancellation/missed session fees.

Please check & initial one of the two options below.

☐_____I authorize the Practice to act as my agent helping me obtain payment from my healthcare provider. I also authorize the release of necessary information to the insurance company for the pursuit of payment. If my healthcare company changes, it is my responsibility to let the Practice know immediately. If not, I will be responsible for payment of the balance on my account. I authorize insurance payments directly to the Practice.

☐_____I do not authorize the Practice to contact my healthcare provider for 3rd party payment. I understand that if I have insurance and have decided not to process any claims through my insurance company for any reason, I am personally obligated to pay the private pay/non-insured rates and waive any rights to a reimbursement rate as provided under my insurance policy. If at any time I choose to seek reimbursement for my services through any insurance policy, I will notify the Practice and amend this section to provide for reimbursement for any prospective appointments and waive my rights to any prior completed appointments and costs.

TELEPHONE AND EMERGENCY PROCEDURES:

If, on occasion, it is necessary to contact the Practice between sessions for a purpose other than scheduling and payment, and you are not able to reach him/her directly, the Practice will make every effort to return your call within 24 hours, with the exception of weekends and holidays. Due to your

therapist's work schedule, your therapist is often not immediately available by telephone. While your therapist may be in the office, your therapist is generally in session and unable to answer the phone immediately. If your therapist is or will be unavailable for an extended period of time, the Practice will either provide a covering therapist's contact information on your therapist's voicemail message or provide you with the name of a colleague to contact, if necessary. The Practice is unable to guarantee continuous 24-hour crisis services. In the event of an emergency or a life-threatening situation, go to the nearest local emergency room or call 911.

COMMUNICATION:

I authorize the Practice to communicate with me in the following ways: (Please Check & Initial)

☐_____Call / ☐_____ Leave a message - Cellular phone _____

☐_____Call / ☐_____ Leave a message - Home phone _____

☐_____Call / ☐_____ Leave a message - Office phone _____

EMAIL AND TEXTING:

Because email and texting are inherently insecure, these modes of communication are not allowed unless you specifically direct the Practice to utilize this mode of communication. Please note that the regular use of email or texting is not HIPAA compliant and does not meet the ethical standards of therapists in the State of Illinois. Absent your specific direction to use these modes of communication, the Practice will only utilize them in cases of emergency. Please do not email or text content related to your therapy sessions. If you choose to communicate by email or text, there is no contemplation of privacy. While it is unlikely that anyone will see or acquire copies of any such communication, they are, by their nature, not secured.

☐_____Communicate by Email: _____

☐_____Communicate by Text: _____

TERMINATION OF THERAPY:

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination, in collaboration with the Practice. Except in cases of emergency, or should your therapist not be able to contact you, your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or the Practice determine you are not benefitting from treatment, either you or the Practice may elect to initiate a discussion of your treatment alternatives and/or notify you of intention to terminate. In the unfortunate circumstance that you have an outstanding balance with the Practice and you do not enter into an agreement to resolve the payment of the outstanding balance with the Practice, the Practice will initiate termination. If possible, upon termination your therapist will attempt to provide you with referral resources.

DIVORCE/SEPARATION AGREEMENT:

When the Practice provides services to individuals, children or adults, of families experiencing separation or divorce, the purpose is to aid the patient whom the Practice is seeing through the challenges inherent with these trying circumstances, not to become a witness in the proceedings. Your therapist will not participate in or provide opinion in any custody arrangements, visitation schedules, or other family court

matters.

HIPAA: (Please Check & Initial)

HIPAA: I understand, and have been given a copy of, the Privacy Notice as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the notice I do not understand.

CONSENT TO TREATMENT OF MINORS UNDER 18 YEARS OLD (If Applicable):
This section must be completed by the parent or legal guardian of each minor who attends therapy sessions.

I certify that I am the Mother, Father, or Legal Guardian and have legal authority to consent to mental health services for the above-named patient and accept financial responsibilities for any services provided by the Practice. I, hereby, give my authorization and consent for the patient to receive outpatient treatment from the Practice.

Please note that minors 12 years of age and over have many privacy rights similar to adults, however, in the event that the minor is making poor decisions that are dangerous and rise to an imminent risk of harm, disease, or death the parent will be notified immediately.

I hereby consent to the treatment of the above identified patient subject to the terms outlined hereinabove:

Patient name: _____ Birthdate: _____

Patient/Parent/Legal Guardian name: _____ _____

Patient/Parent/Legal Guardian signature: _____ _____

Date: _____

GUARANTEE
I, as guarantor/person assuming financial responsibility understand that I will be unconditionally responsible for the payment of any uncovered services, costs, and expenses provided to the above identified patient in return for providing services to the identified patient. It is understood that as guarantor of payment I agree that prior to discontinuance of my unconditional responsibility to pay for charges contemplated in this document, I shall give no less than 90 days' notice of my intent to discontinue to the Practice in writing.

Guarantor's Name: _____

Address: _____

_____

Guarantor's Signature (if applicable): _____ Date: _____