**North Suburban Counseling, P.C.**
1170 East Belvidere Road, Suite 201
Grayslake, Illinois 60030
847-548-0492 Phone 847-548-0537 Fax

## Consent for Treatment

I, _____ , hereby affirm that I am 12 years of age or older, and hereby give my consent to be treated and receive an assessment and/or mental health services from the North Suburban Counseling, P.C. clinical staff.

Signature _____ Date _____

**Patients under the age of 18 must have the bottom portion of this consent completed by a parent or guardian.*

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**Consent for Treatment of a Minor (Under 18) /**
**Consent for Treatment of an Adult Who Has a Legal Guardian**

I, _____ , hereby affirm that I am the legal guardian of _____ , and hereby give my consent for him/her to receive an assessment and/or mental health services from the North Suburban Counseling, P.C. clinical staff.

Guardian Signature _____ Date _____

**This consent is recognized for counseling patients under the age of 12.*

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# Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your clinician and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your clinician to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. The PHI may include diagnosis, treatment plan and medication, if necessary.

## Patient Authorization

☐ I agree to release any applicable mental health/substance abuse information to my PCP:

My Primary Care Physician is _____

Address _____

Telephone Number _____

☐ I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services and I direct you NOT to notify him/her.

☐ I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

## Patient Rights

You can end this authorization at any time by contacting your clinician at (847) 548-0492.

If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission.

You cannot be required to sign this form as a condition of treatment.

You have a right to a copy of this signed authorization. Please keep a copy for your records.

You do not have to agree to this request to use or disclose information.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization. This authorization shall expire one year from the date signed unless revoked prior to that date.

Patient Signature _____ Date _____

**Notice to Recipient of Authorization**

*This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.*

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## Outpatient Service Fees

### Initial Evaluation

| | |
|---|---|
| 60 Minute Initial Evaluation | $230.00 |

### Individual Therapy

| | |
|---|---|
| 60 Minute Individual Therapy Session (PhD or MA Licensed Therapist) | $175.00 |
| 45 Minute Individual Therapy Session (PhD Licensed Therapist) | $160.00 |
| 25 Minute Individual Therapy Session (PhD Licensed Therapist) | $ 95.00 |
| 45 Minute Individual Therapy Session (MA Licensed Therapist) | $140.00 |
| 25 Minute Individual Therapy Session (MA Licensed Therapist) | $ 80.00 |

### Couple/Family Therapy

| | |
|---|---|
| 45 Minute Couple or Family Therapy Session (PhD Licensed Therapist) | $180.00 |
| 45 Minute Couple or Family Therapy Session (MA Licensed Therapist) | $160.00 |

### Group Therapy

| | |
|---|---|
| 60-90 Minute Session | $ 80.00 |

### Consultations

| | |
|---|---|
| Attendance at school or placement staffings, impartial due process hearings, court proceedings, consultations with other professionals, or any other meeting at your request *Per Hour (including travel time)* | $250.00 |
| Telephone Consultation with patients or authorized others for therapeutic purposes, Per 15 minutes | $ 50.00 |
| 45 Minute Telephone Consultation (*NOT covered by MOST Insurance companies*) | $170.00 |

### Other Professional Services

| | |
|---|---|
| Preparation of records, treatment summaries, report writing, or other written reports at your request. *Billed in 15 minute increments* | $200.00/hr. |

My clinician has explained the NSC fees to me and I understand the above charges. I have also been provided with an itemized list of these fees.

Patient Name _____ Date _____

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## Financial Policy

We invite you to discuss frankly with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. The following is a statement of our financial policy, which we require you read and sign prior to any treatment. Our office policy requires payment in full (co-payments or deductibles) at the time of your visit.

We will be happy to file for insurance reimbursement: however, it should be understood that you are ultimately responsible for payment of services rendered. You must sign this form if you wish our office to file for insurance reimbursement. You are responsible for your deductible, co-insurance, and any service not covered or rejected by your plan.

If we do not submit your insurance for you, you are responsible for payment in full. If you do not agree with your insurance company's coverage, it is YOUR responsibility to work it out with them. Your contract is between you and your carrier. We are not involved with that contract. Payment must be made to us by you in FULL at the time of service. It is important to note that each mental health provider at NSC may be covered differently under your insurance plan. NSC mental health providers are credentialed individually by insurance companies, so referrals within NSC do not guarantee the same coverage from your insurance company. It is your responsibility to confirm proper coverage from your insurance company for each NSC mental health provider.

- If your account is turned over to collections for any reason, you are responsible for all collection and attorney's fees associated with the collection process.
- If you cancel your appointment without 24-HOUR NOTICE, there will be a full fee charge assessed to your account. Insurance plans do not cover missed appointments.
- Our fee for returned checks is $30.00 per occurrence.
- If your balance exceeds $300.00, we will need to ask that you pay for services when rendered. After 90 days any unpaid balance will be charged 1.5% interest a month (18% APR)

I authorize the provider to release any information required to process insurance claims and authorize payment of benefits to the provider.

I agree with and understand the statements above.

Name _____ Date _____

Signature of Responsible
Party or Guardian _____ Relationship _____

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# Risks & Benefits of Treatment / Patient Acknowledgement

### Introduction: A Genernal Description of Treatment

Participating in treatment may result in a number of benefits to you, including improving interpersonal relationships, and resolution of part or all of the concerns that led you to seek therapy. Therapy may also help facilitate positive growth and development. Working towards these benefits, however, requires effort on the part of the patient. Psychotherapy requires very active involvement, honesty, and openness in order to change thoughts, feelings and/or behaviors. The therapist will ask for feedback from the patient regarding views on therapy, progress and other aspects of treatment. During treatment, remembering or talking about unpleasant events, feelings or thoughts can result in considerable discomfort or strong feelings and it is possible that experiences of anxiety, depression, insomnia or other discomfort may temporarily increase. The therapist may challenge some of the patient's assumptions, or propose different ways of looking at situations, which can cause uncomfortable feelings. Attempting to resolve the issues that brought the patient to therapy in the first place may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it is slow and frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

### Methodologies Utilized

During the course of therapy, the therapist is likely to draw on various methodologies depending on the presenting problem and what is, in the therapist's professional judgment, in the best interest of the patient. If the patient has any questions about any of the procedures used in the course of treatment, including risks, the therapist's expertise in employing them, or about the treatment plan, the patient should not hesitate to ask. Patients also have the right to ask about other treatment methodologies. If the therapist concludes that the patient could benefit from any treatments that the therapist does not provide, there is an ethical obligation to assist the patient in obtaining those treatments, should it be in the patient's best interest.

### Consultation with Other Qualified Professionals

All therapists consult regularly with other highly qualified professionals regarding their patients; however, patients' names or other identifying information are never mentioned and confidentiality is fully maintained.

### Initial Assessment / Termination of Treatment / Referral to Others

After the first few sessions, the therapist will assess if he/she can be of benefit to the patient. A competent clinician does not accept patients who, in his/her professional judgment, he/she cannot help. In such instances, the therapist refers the patient to other professionals. In addition, if at any point during treatment the therapist assesses that he/she is not effective in helping the patient, termination of treatment and referral to others is an ethical obligation that cannot be circumvented. Finally, all patients have the right to terminate treatment at any time, for any reason. If this is the patient's choice, the therapist will offer to provide names of other qualified professionals.

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## Risks & Benefits of Treatment / Patient Acknowledgement



### Neglect and Abuse of Children

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services ("DCFS"). We are mandated reporters, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that an abuse or neglect situation exists. If this is so in the mind of the therapist, the law absolutely requires that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of North Suburban Counseling, P.C. ("NSC") to first advise that the report will be made. Subsequent to a "mandated" report, the patient, and possibly others, will be contacted by a follow-up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded". The therapist has no choice but to make reports in these situations. The patient should be aware that the statute provides for loss of license if a therapist fails to make a mandated report. The statute also provides the therapist with absolute immunity from any criminal or civil liability in the event that such a report is made, even without the consent of the patient.

### Duty to Warn of Physical Injury

Another Illinois statute, the DMHDD Confidentiality Act, mandates a therapist to "warn" any intended victim, as well as the responsible authorities, when a patient discloses in session that he or she intends to cause physical harm to a specifically identifiable victim. It is then the therapist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring. Therefore, if a patient discloses an intent to harm a specific person, we must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

### Acknowledgement of Patient

I, the undersigned, am a patient of North Suburban Counseling, P.C. My therapist has shared the above policies with me and has explained their implementation and significance and I fully understand them. I have also been advised that North Suburban Counseling, P.C. has offered no guarantees as to the success, or as to a specific outcome, of my treatment. A copy of this document is available to me upon request.

Name _____ Date _____

Signature _____ Witness _____

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## Patient Bill of Rights & Responsibilities

As a patient receiving care or service from NSC, you have the right to:

- receive respectful treatment without discrimination
- receive a particular type of treatment or end treatment without obligation or harassment
- a safe environment, free from sexual, physical, and emotional abuse
- report unethical and illegal behavior by a clinician
- ask questions about your treatment
- request and receive full information about the clinician's professional capabilities, including licenses, education, training, experience, professional association membership, specialization, and limitations
- have written information about fees, methods of payment, insurance reimbursement,emergencies and cancellation procedures.
- refuse to answer any questions or disclose any information you choose not to reveal
- know the limits of confidentiality and the circumstances in which a clinician is legally required to disclose information to others
- know if there are supervisors, consultants, students, or others with whom your clinician will discuss your case
- request, and in most cases receive, a summary of your file, including the diagnosis, your progress, and type of treatment
- request the transfer of a copy of your file to any therapist/physician or agency you choose
- receive a second opinion at any time about your treatment from a different clinician
- request that the clinician inform you of your progress

I, the undersigned, am a patient of the NSC practice. My clinician has shared the above policies regarding required disclosures with me, and has explained their implementation and significance. I have been given a copy of this document, and fully understand it. I have also been advised that NSC has offered no guarantees as to the success, or as to a specific outcome, of my treatment.

Name _____ Date _____

Signature _____ Location _____

Witness _____ Title _____