

Contract, Office Procedure, and Financial Agreement

North Shore Wellness Services, Ltd.

(Independent Practitioners and Employees)

3000 Dundee Rd., #411-412

Northbrook, IL 60062

(847) 205-0371

Please read and sign two copies. Keep one for your records

North Shore Wellness Services, Ltd., is a business facility where a number of mental health professionals practice. **Some therapists are independent practitioners and others are employees, working under the supervision of an independent practitioner. Your contract for services is with your therapist only and does not include a contract with any of the other therapists at this site.**

Rights and Risks: · Please feel free to ask questions about any aspect of the counseling process. · If you have been referred by a court or state agency, you have the right to divulge only what you want to be included in a report. · You need to be willing to discuss what troubles you and be open to change. · You may remember unpleasant events, arouse intense emotions, and/or alter close relationships.

Confidentiality: · Information shared will be held in confidence. · Information will not be released without your written consent, except for professional consultation if needed and unless required by law. · Your therapist is required by law to disclose information pertaining to suspected child abuse; inability to care for one's basic needs for food, clothing or shelter; and threatened harm to oneself or others. · The courts may in select cases subpoena counseling records. · It is understood that information regarding treatment and diagnosis may be provided to an insurance company. · You may want to discuss further limits or exceptions of confidentiality.

Client Agrees to: **Allow the therapist to be assisted by a co-therapist if either or both deems it appropriate.**

Note on Privacy: *I understand that the counseling sessions in which I participate with a co-therapist is for the purpose of improving my care, and not an invasion of my rights of privacy; therefore, in consideration of the benefits received by me, I specifically waive my rights of privacy for this purpose only.*

Appointments: · All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. · **Late cancellation (less than 24 hours before) and/or no-show appointments are billed to the client for the full amount.** In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get the voice mail. If your appointment is cancelled or missed, contact your therapist for a new appointment time. **Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.**

Fees:

· The client portion (co-pay or full amount) of fees is expected at the time of service.

· Your health insurance may help you recover some of your counseling costs. Most group policies, but few individual policies, cover outpatient psychotherapy. Please verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals. **If your policy requires preauthorization to receive services, this is your responsibility and needs to be handled prior to your first visit.**

****By signing this contract, you acknowledge responsibility for payment per hour for any demand on the therapist's time that occurs under your direction on your behalf. This includes time demands that result from involvement in any legal proceeding. The fees are included on page 2.**

Uninsured clients are expected to pay their fees as services are rendered. Our office will only bill directly to Blue Cross Blue Shield of Illinois, excluding non-PPO policies or companies subcontracted by Blue Cross/Blue Shield. Non-BCBS PPO clients will be provided an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account. This office will not accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. Clients are responsible for payment (and insurance claims) on their accounts.

Failure to pay your part may jeopardize your benefits. Copays are not negotiable.

Clients paying on a cash basis and not billing any insurance company are expected to pay in full at time of service unless a payment plan has been previously arranged. Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable. Accounts become delinquent after thirty (30) days. Delinquent accounts may be turned over for collection.

Phone calls over five (5) minutes will be billed in 15 minute increments, at \$40 per 15 minutes. This will not be processed by insurance and will be owed from the client to the therapist.

Any change in my financial situation I will discuss with my therapist. I have read, understand and agree to the above policies. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies to take with me if I desired. I hereby authorize North Shore Wellness Services, Ltd. and my therapist to release to my insurance company any information acquired in the course of my therapy (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by or on account of this client and hereby assign North Shore Wellness Services, Ltd. (NSWS) and all Insurance benefits due to me to the full extent of my financial obligation to NSWS. I have read and/or received a copy of North Shore Wellness Services, Ltd., Privacy Policy. *If conjoint (couple or family) all adults need to sign this contract because of confidentiality and your rights, even though one person is the identified patient.*

	Up to 50-minutes	60-minutes	75-minutes	90-minutes	Per additional 20-30 minutes
Initial Intake Interview/Assessment	\$206	\$206	\$206	\$206	
Private counseling session	\$126	\$150	\$183		\$89
Client with Family	\$153	\$153			
Family without Client Present	\$123				
Individual Play Therapy	\$136	\$175	\$198		
Consultation w/ Family to Assist Pt	\$123				
Cancelled w/in 24-hours or missed	\$126	\$150	\$184	\$200	
Depositions, subpoenas, and/or court proceedings		\$300			\$150

Client(s) Signature(s): _____ **Date:** _____

Client(s) Signature(s): _____ **Date:** _____

In the event that I cancel an appointment within 24-hours or fail to attend a scheduled appointment, I hereby authorize North Shore Wellness Services, Ltd., to charge to my credit card the amount of the cancellation or missed appointment fee, in the amount of \$125 for a scheduled 50-minute session, or \$184 for a scheduled 75-minute session.

Card: Credit Card # Exp. Date:
 VISA MC AMEX DISC □□□□-□□□□-□□□□-□□□□ □□/□□

Billing Address of Credit Card:

 Street City/State Zip Code

 Client Signature Date

Go Paperless! By providing your email address and signature below, you authorize NSWS to issue you invoices and statements via email. You may withdraw your consent at any time by providing a request in writing.

_____ @ _____
Email address

Signature

Emergencies: The **best phone number** for you to call is the direct phone number of your therapist. If you receive the voice mail, please leave a message for your personal counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, if your therapist cannot be reached you may call the main line 24 hours a day (847) 205-0371, or go immediately to your local emergency room.