799 Roosevelt Rd, Bldg 4, Suite 303, Glen Ellyn, IL 60137

Informed Consent

We would like you to have a clear understanding of the services we provide. This document is intended to inform you of our policies, state and federal laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Services provided by this practice include diagnosis, treatment planning, and counseling services. Our desire is to partner with you as you try to improve your quality of life. Part of what sets our practice apart is the knowledge of our clinicians and the experience they have in working with the struggles that come with living.

Confidentiality and emergency situations: Your verbal communication and clinical records are strictly confidential except for: a) information shared with your insurance company to process your claims, b) we become aware of any real or alleged abuse to children, elderly, or incapacitated people (in which case we are mandated reporters to the State of Illinois) c) where you sign a release of information to have specific information shared and d) if you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency arises for which the client or their guardian feels immediate attention is necessary, contact 911 or the DuPage Crisis line 630-627-1700. At your earliest convenience, please inform your therapist of the situation and they will respond in a manner that is clinically indicated. Please be advised that E-mail and text messages are not confidential and your therapist may not be able to respond.

Client Signature (12 and over)__________________________________Date:_______

Guardian Signature __________________________________Date:_______

How do you prefer to be contacted by your therapist? ___________________________

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Financial/Insurance issues: Initial sessions are $160. Standard sessions are $135. Telephone consults less than 10 minutes are complimentary if not overused. Phone sessions that last more than 10 minutes will be charged to the client directly, as phone sessions are not covered by insurance. Phone sessions are the same cost as office sessions. Payment is due at the time of service. Any checks returned by the bank will incur a fee. Any balances unpaid after 90 days will be forwarded to collections, and will incur a 25% collection fee. If we are unable to bill your insurance company, you will be considered a self pay client and must pay in full at time of session. You will be given a receipt for your session, which you may use to request reimbursement from your insurance company. If you receive an insurance payment meant for us, we ask that you send payment to us immediately.

Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed an **$85 cancellation fee**, which insurance will not pay. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. **You may have a copy of this form if requested.**

Signature(s)____Date________

Coordination of treatment: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no inform will be shared.

____You may inform my physician(s) ____I decline to inform my physician

Physician name: ____
Clinic: ____
Address: ____
Phone: ____

Client Signature (12 and over)___________________________________Date:_______

Guardian Signature ___________________________________Date:_______

Notice of privacy practices and client rights: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)____ Date: _______________

Consent for treatment of children or adolescents: I/We consent that ____ may be treated as a client by DuPage Counseling Associates, Inc.. It is understood that children the age of 12 and over have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Client Signature (12 and over)____________________________________Date:_______

Guardian Signature ____________________________________Date:_______