Contract, Office Procedures, and Financial Agreement

North Shore Counseling, Ltd.
(Formerly North Shore Wellness Services, Ltd.)
425 Huehl Rd., Bldg. 19B Northbrook, IL 60062
(Phone) 847- 205-0371 (Fax) 847-205-0377 (Web) www.northshorecounseling.com

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

North Shore Counseling, Ltd., is a business facility where a number of therapists engage in the practice of mental and behavioral health services delivery ("counseling"). Some therapists are licensed to practice independently and others require supervision. Those who require supervision work under the direction and supervision of a fully credentialed practitioner. Your contract for services is with North Shore Counseling, Ltd.

Rights and Risks: · Please feel free to ask questions about any aspect of the counseling process. · 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. The purpose of counseling is to facilitate your process. · If you have been referred by a court or state agency, you have the right to divulge only what you want included in a report.

Confidentiality: · Information shared will be held in confidence with certain limitations. · 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 or elder abuse or neglect; 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 will be provided to an insurance company if you opt to bill your insurance company for services. · You may want to discuss further limits or exceptions of confidentiality.

Client Agrees to: ☐ ***Allow the therapist to be assisted by a co-therapist or supervisor.*** **Note on Privacy:** *I understand that any counseling session in which I participate with co-therapists is for the purpose of improving my care, and not an invasion of my rights of privacy.*

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 53 minutes. **· Late cancellation (less than 24 hours before) *and/or* no-show appointments are charged to the credit card on file for the full amount.** 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:

- Payments and copayments for services are required at the time services are rendered.
- Your health insurance may help you recover some of your counseling costs. 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. If required preauthorization is not on file, your credit card will be charged for your session.**
- Regardless of your intention to use insurance, the **"Insurance Declaration Form"** MUST be on file before services can commence.
- By signing this contract, you acknowledge responsibility for payment per hour for any demand on the therapist's time that occurs under your direction and/or on your behalf. This includes time demands that result from involvement in any legal proceeding. The fees are detailed on page 2.

"Self Pay Clients" as defined in our Insurance Declaration Form are expected to pay their fees at the time services are rendered. Our office will provide an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account, either in paper copy or via email when we are granted permission to do so. This office will not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. Clients and parents/guardians of minor clients are responsible for payment (and insurance claims) on their accounts. Accounts become delinquent after thirty (30) days. **Delinquent accounts may be turned over for collection at the responsible party's expense.**

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 North Shore Counseling.

CLIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND ACCEPTANCE OF TERMS: Any change in my financial or insurance situation I will discuss with my therapist. I have read, understand, and agree to the above policies and the fee schedule on Page 2 of this contract. 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 and understand a copy is available on line. I hereby authorize North Shore Counseling, Ltd. and my therapist to abide by my expressed preferences on the Insurance Declaration Form I submitted with this contract. 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. I understand that Co-pays and Deductibles are not negotiable.**

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by me and/or on account of this client and hereby assign North Shore Counseling, Ltd. (NSC) and all Insurance benefits due to me to the full extent of my financial obligation to North Shore Counseling. I have read and/or received a copy of North Shore Counseling's Privacy Policy. *A completed Insurance Declaration Form is required for my file.*

FEE SCHEDULE
I acknowledge and understand the fee schedule, detailed in the table below. I understand that the STANDARD portion of the fee schedule may be submitted to my insurance company for payment if I authorize NSC to do so on my behalf. I understand and accept that I am responsible for copays and deductible amounts.

I understand that that the "ADDITIONAL" portion of the fee schedule is not billable to insurance and will not be paid for by a third party. Any "ADDITIONAL" fees incurred by me or by my dependent child are my sole responsibility.

STANDARD FEES	0-30 minutes	31-53 minutes	53-60 minutes	Flat Fee	
Initial Intake Interview/Assessment				$207	
Individual Counseling Session	$75	$130	$150		
Multiple Family Members/Clients Counseling Session	$100	$204	$204		
Consultation w/ Family – client is not present				$150	
ADDITIONAL FEES (to be paid by the undersigned)	5-60 minutes				Additional 30 minutes
Counseling Session after first 60 min	--				$75
Consultation with outside agencies/schools	$150				$75
Cancelled w/in 24-hours or missed	--			$125	
Depositions, subpoenas, legal 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 Counseling, Ltd., to charge to my credit card the fee of $125.

Credit Card # Exp. Date: _____/_____

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Billing Address of Credit Card:

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Street City/State Zip Code

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Name as it Appears on Card Client Signature Date

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

____________________@___________________________ _______________________________

Email address **Signature**

Emergencies: The **best phone number** for you to call is the direct phone number of your therapist. If your call goes to voice mail, please leave a message for your counselor. Your counselor may be on the phone, in therapy with someone else, or out of the office. In a crisis situation, call 911 *or* go immediately to your local emergency room.

Rev. 1/2/2014