2018

Contract, Office Procedures, and Financial Agreement

North Shore Counseling, Ltd.

(A DBA of 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 counselors are licensed to practice independently and others require supervision. Those who require clinical supervision work under the direction and clinical supervision of Victoria Fleming, Ph.D., License #180-005618. Your contract 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. *Refer to our Privacy Policy in a separate document for details.* 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. ·

Privacy: *By signing this contract, I acknowledge receipt of the separate Notice of Privacy Practices of North Shore Counseling. I understand North Shore Counseling utilizes an on-line practice management system, TherapyNotes, LLC, to store and maintain my records. I understand there are certain risks associated with on-line storage of personal information, and I will hold North Shore Counseling and its employees harmless in the event of a breach of confidential information that is beyond the control of North Shore Counseling. 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. If my counselor is a Licensed Professional Counselor (LPC), then I understand he/she is working under the direct supervision of Victoria Fleming, Ph.D., License #180-005618. The supervisor has responsibility for my clinical care, and as such, will have access to my file and will consult with my counselor about my case.*

Appointments: · Office visits are by appointment only. 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 contracted 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. Clients can request appointments at the on-line scheduling portal: https://www.therapyportal.com/p/northshore60062/

Fees:

- Payment for services are required at the time services are rendered. The **"Insurance Declaration"** MUST be on file before services can commence.
- 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.**
- 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.**

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**	**31-52 minutes**	**53-60 minutes**	**Flat Fee**	
Initial Intake Interview/Assessment				**$220**	
Individual Counseling Session	**$100**	**$150**	**$200**		
Multiple Family Members/Clients Per Person Fee	**$100**	**$110**	**$125**		
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**	
Phone Calls 5-15 min in length				**$40**	**$75**
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 Type: Visa☐ MC☐ AMEX☐ DISC☐ Security Code_____ Exp. Date: _____/_____

☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

Billing Address of Credit Card:

_____

Street City/State Zip Code

_____

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. 12/21/2017