1300 W. Belmont Ave. Ste. 407A
Chicago, IL 60657

Client Information and Service Agreement

I look forward to working with you. In order to begin our work together I'd like you to read the following information in preparation for our first appointment. Please let me know if you have any questions.

Treatment Guidelines

- Appointments last 55 minutes

- All issues discussed in session and all written records of services are confidential and cannot be released to another person or agency without client approval. However, clients using insurance may be required to release additional information, which varies from plan to plan. The therapist is also legally obligated to break confidentiality in the following cases:
    - The client presents a clear and imminent risk to his/herself or others.
    - The client discloses or there is suspicion of neglect, physical abuse, sexual abuse or financial exploitation of minors, a dependent adult, or the elderly.
    - There is a court ordered valid subpoena.

- Clients may contact their therapist via phone and e-mail. The therapist will not charge for return calls or e-mails under 10 minutes in duration. The therapist will charge for any time exceeding 10 minutes at a rate of $25 per 15 minute increment. Clients are responsible for this fee, as insurance cannot be billed.

- The above phone or e-mail consultations are not intended for crisis or emergencies. In the advent of an emergency that threatens the health or well-being of yourself or someone else and requires immediate assistance, you are to call 911 or go to the nearest hospital emergency room.

- The goal of therapy is to help resolve personal difficulties. The therapist will attempt to help clients feel comfortable during sessions and assist them in meeting their goals. However, clients should be aware that psychotherapy may periodically produce heightened

feelings of emotional distress or discomfort. If this occurs, clients should notify their therapist in order that the symptoms are properly addressed.

- Sobriety is a prerequisite for attending counseling

- In order to ensure proper treatment, the therapist may seek outside consultation at times with another clinical professional in order to discuss the case. In order to protect confidentiality, no identifying information will be provided to the consultants.

- At least 2 weeks notice is requested prior to termination of therapy.

Fee and Payment Guidelines

- Counseling session fees are $160 for the initial consultation and $150 per follow up sessions. Cash or check is accepted at time of service.

- If going through insurance (BC/BS) please check with your insurance carrier prior to session to determine coverage and benefit information. The therapist is not responsible for finding this information. Please be prepared to pay your co-pay, any deductibles or non-covered procedures by cash or check.

- Your session time is reserved exclusively for you. If you are unable to make your appointment, please **CALL** to cancel at least 24 hours in advance to 312-560-9005 for Alison & 262-893-0481 for Jen. If you do not call 24 hours in advance of your session **you will be charged in full for your session ($150).** Insurance cannot be billed for missed or late cancelled sessions.

- Payment in full or co-pays/co-insurance are due at the end of each session unless other arrangements have been made.

- If the client has another type of insurance, I am happy to provide the client with a receipt that they may submit to any insurance for reimbursement. Fee for the session will need to be paid at the end of each session.

- Clients will be charged a $25 fee for returned checks.

- Client gives counselor permission to send invoices electronically_____
  Initial

Insurance Billing Authorization

Client Name:________________________ DOB:_________________

Street Address: ______________________________ Zip: _________

Home Phone:______________________ Cell Phone:____________

Employer: ____

Policy Holder's Name (if different than client): ____________________

Relationship to Client: _________________________DOB: ________

Street Address (if different than client): _________________________

Home Phone: _____________________ Cell Phone: ____________

Employer: ____

Insurance Provider: ____

Group #: ____________________ Member ID: _________________

Insurance Provider's Phone: _________________________________

Client Consent to Terms of Agreement

I, the undersigned understand and accept the Client Information & Service Agreement and request services from Third Coast Wellness, P.C.

I give Third Coast Wellness, P.C. permission to release any information obtained during treatment that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges regardless of insurance coverage. I hereby assign medical benefits, to be paid to Third Coast Wellness, P.C. A photocopy of this assignment is to be considered as good as the original.

____________________________________ ______________

Signature of the Client or Parent/Guardian Date

___________________________________ ______________

Signature of Partner (for couples sessions) Date