CORE
Psychotherapy Center

INFORMED CONSENT

Thank you for choosing **Core Psychotherapy Center.** Today's appointment will take approximately 45 – 60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

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)** information you and/or your child or children report about physical or sexual abuse (Illinois State Law requires that this be reported to the Department of Children and Family Services), **c)** where you sign a release of information to have specific information shared and **d)** if you provide information that informs me that you are in danger of harming yourself or others **e)** information necessary for case supervision or consultation and **f)** or when required by law.

E-mails, text messages and social networking sites are not confidential and your therapist may not be able to respond. Please note that therapists are often not immediately available to take telephone calls. Please leave a message in your therapist's voice mail and your therapist will respond to your call as soon as your therapist is able. If there is a clinical emergency that you cannot wait for a return call please dial 911 or go to your nearest emergency room.

Signature: _____ Date: _____

FINANCIAL/INSURANCE ISSUES: **The session fee is the sole responsibility of the patient.** As a courtesy we will bill your primary insurance company if you wish. We do not bill secondary insurance.

It is the obligation of the patient to know their insurance and/or EAP benefits. This includes, but is not limited to co-pay amounts, number of sessions authorized, pre-authorization necessity and capitation of insurance or EAP benefits. Payment of any fees, outside the portion covered by insurance, are due at time of service. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full insurance contracted fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time.

Please note that insurance companies require a clinical diagnosis be provided to the insurance with billing. This information may become part of your permanent medical record. If you have any questions regarding this please speak to your therapist.

48 hours notice of cancellation is required. If cancellation is made less than 48 hours, you will be charged a $125.00 cancellation fee. It is understood that an appointment time has been reserved for you and lack of notice prevents sufficient time to schedule other patients. Your insurance company and/or EAP cannot be billed for failed appointments. **You will be responsible for the $125.00 fee.** Payment for the missed appointment is required prior to or at the beginning of the next session.

For your convenience, and to guarantee payment for services, we request documentation of a major credit card. In the event that your account becomes past due, we will charge your card any remaining balance due. All open balances will be billed on a monthly basis. Missed appointment charges will be charged to your card.

Client Name_____

Credit Card #_____**Exp**_____

Cardholder Name_____**Billing zipcode**_____

CID (security code on back of card)_____
I authorize Core Psychotherapy Center to charge my credit card listed above for past due balances and missed appointment fees. I authorize Core Psychotherapy Center to keep my signature on file for future charges as authorized by me.

Cardholder Signature_____**Date**_____

All phone calls (whether to parents, school personnel, GAL, physicians, evaluators, etc.), report writing, evaluations, and other work including, but not limited to, file review and research related to the treatment or services provided, will be billed at quarter hour segments ($225 per hour). You will also be billed at the rate of $50.00 per request for medical record requests. Insurance will not cover this expense.

We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask the office manager.

Signature: _____Date: _____

LITIGATION LIMITATIONS

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to matters which may be confidential in nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce, custody disputes, injuries, lawsuits, etc.) neither you, the patient, nor your attorney, nor anyone else acting on your behalf will request that anyone from Core Psychotherapy Center testify in court, give depositions or attend any other legal proceedings, nor will a disclosure of the psychotherapy records be requested.

A treating therapist is an advocate for their patient and cannot offer objective opinions. Expert witnesses provide the courts with their objective opinions based strictly on all evidence provided to them by the parties on both sides of the issue. Core Psychotherapy Center therapists do not act as expert witnesses.

Signature: _____Date:_____

BUSINESS REVIEW SITES: Business Review Sites (Yelp, Bing, Healthgrades, etc.) may display reviews regarding our practice. Please know that it is unethical for those in our business industry to request testimonials. Anyone has the right to express themselves through these sites, but due to confidentiality, we cannot respond to these posts. Please take the opportunity to communicate your feelings and reactions about therapy directly with us.

COORDINATION OF TREAMENT: 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. If you prefer to decline consent no information will be shared. This authorization may be revoked at any time.

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

PHYSICIAN NAME: _____
PRACTICE: _____
ADDRESS: _____

Signature: _____Date:_____

APPROPRIATE BEHAVIOR is expected in and around our offices by patients and anyone accompanying the patient. Parents/Guardians are responsible for their children. Please communicate with your children appropriate behavior expectations in our offices. If any damage occurs, patients will be held financially responsible for property damage and/or vandalism. No child under the age of 13 should be in the waiting room unattended. Our staff is not responsible for babysitting your child in our offices. We cannot control who enters our offices nor if a child should leave the office. Your child is your responsibility.

NOTICE OF PRIVACY PRACTICES: I have read and received a copy of the Notice of Privacy Practices. May we contact you at home? **Yes No**; May we contact you at work? **Yes No**; May we contact you by cell phone? **Yes No**
Which number would you prefer that we call? _____
Please note that our therapists will consider a case closed after 2 months of patient inactivity.

Signature: _____Date:_____