CONTRAST
COUNSELING

3166 N. Lincoln Ave Ste 207
Chicago, IL 60657

Client Information

Legal name: _____

Preferred name: _____ Pronouns: _____

Sex assigned at birth (for insurance): _____ Gender identity: _____

Date of birth: _____ Phone number: _____

Email address: _____

Street address: _____

City, state, zip: _____

Living arrangements (include who is living with client):

_____

Relationship status: _____ Sexual orientation: _____

Race/ethnicity: _____ Primary language: _____

Employer: _____

Referral info (name & phone #): _____

Emergency contact (name & phone #): _____

Relationship to client: _____

Do you have a FOID card? _____ Do you own and/or possess a firearm? _____

Insurance Information

Name of insured person: _____

Relationship to client: _____

Insurance provider (e.g., BCBS or United/Optum): _____

Member ID: _____ Group #: _____

Insurance phone number: _____

Guidelines, Policies, and Other Information

Welcome to Contrast Counseling!

I'm excited for the opportunity to start this process together! The therapeutic relationship is unique in that it is a highly personal and, at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. I will happily address any questions or concerns that come up now or throughout the course of treatment. Please read and indicate that you have reviewed this information and agree to it by signing at the end of this document.

Informed Consent

You have taken such a courageous step by deciding to start therapy. The outcome of your treatment will depend largely on your willingness to continuously engage in this process, which may, at times, result in considerable discomfort. Working through distressing situations, past or present, can bring up a lot of potentially unexpected emotions for some people. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can, however, promise to support you and do my very best to understand what is going on with you, as well as to help you clarify what it is that you want for yourself. Therapy is an incredibly personal process and I will do my best to address your individual needs and concerns using whichever therapeutic tools I believe will best benefit you.

Appointments and Cancellations

Services are by appointment only and individual appointments are scheduled for 45-55 minutes. If you are late for a session, you may lose some of that session time. Because appointment times are reserved exclusively for you, we will have to charge for any appointment that is canceled or rescheduled with less than 24 hours notice. Any missed appointments (i.e., no shows) will also incur the cancellation fee. If you know in advance that you cannot attend your scheduled appointment, please either call (872) 205-6176 or email becky@contrastcounselingchicago.com in order to reschedule.

If you do not provide the appropriate notice as outlined above, you are responsible for the full cost of that session

Insurance and Payment

- All payments (copays, deductibles, out-of-pocket fees, and sliding scale fees) are due at the time of service. The full out-of-pocket rate for therapy services at Contrast Counseling is $200 for a 45-55 minute individual session, $100 for a 30 minute individual session, and $225 for an intake appointment. Fee structures are revised at the beginning of each year, and rates may change, but only at that time.

- If you have a Blue Cross Blue Shield PPO or a United/Optum PPO plan, we are in-network providers and will submit claims directly to your insurance for you. We will gladly help you verify your benefits and the cost you will owe depending on your plan prior to the first session. Please note that a quote of benefits is not a guarantee of coverage and if your insurance company denies payment or does not cover counseling, we will request that you pay the balance due at that time.

- If you have any other health insurance plan, we are happy to assist with verifying out-of-network benefits and will provide documentation for you to obtain reimbursement.

- If you do not have insurance, reduced fee rates are available upon request. In order to reserve these spots for those who need it most, eligibility for a reduced feeis determined by completing an application and submitting supporting documentation.

- Acceptable payment methods include credit card or check. A $10.00 service charge will be charged for any checks returned for any reason for special handling.

- In the event that an account is overdue and turned over to a collection agency, you will be held responsible for any collection fee charged to our office to collect the debt owed.

Right to Receive a “Good Faith Estimate of Expected Charges”

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, health care providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.
    - For questions or more information about your right to a Good Faith Estimate, visit **www.cms.gov/nosurprises**

Communication and Emergencies

- In order to be accommodating, we may communicate via phone, text, or email at times depending on what is most effective. Please note that phone calls and text messages are not secure forms of communication should you choose to utilize those.
- We always do our best to check and return all forms of communication within 24 business hours. Please note that we do not return missed calls when a voicemail is not left.
- *If you are experiencing a psychiatric emergency, please always call 911 or go to your nearest emergency room*.

Social Media Policy

Due to the importance of your confidentiality and the importance of minimizing dual relationships, I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). I believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Minors

If you are a minor, your parents may be legally entitled to some information about your therapy. I will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

Termination

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used or if you are in default on payment. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source.

Should you fail to schedule an appointment for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

Confidentiality and Consultation

All information regarding you, your treatment, and the fact that you are receiving treatment is confidential and will not be released to anyone outside of Contrast Counseling without your written consent. Your confidentiality is protected both by ethical practice and Illinois law. There are, however, several important legally mandated exceptions to confidentiality laws: in situations where your therapist determines you are a potential harm to yourself or others, in cases of suspected child or elder abuse or neglect, or in legal proceedings when the court subpoenas records. We are also required by the state of Illinois to report if you are a danger to self or others and own a firearm (Public Act 095-0564).

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

Consultation is an important part of providing quality treatment and as such, your therapist may seek consultation and supervision from other licensed therapists. These consultants are also legally bound to keep the information confidential and adhere to the same strict ethical guidelines as our practice. Your name and any unique identifying characteristics will not be disclosed during any professional consultation.

By signing this form, I acknowledge that I have read, fully understand, and agree to all information contained here.

_____ _____

Signature Date

CONSENT FOR TELEHEALTH CONSULTATION

I understand that my health care provider wishes me to engage in a telehealth consultation.

My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.

I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Signature Date

Credit Card Payment Authorization

Client name: _____

Name on card (if different): _____

Billing address: _____

_____

Card #: _____

Expiration date: _____ CVC # (on back of card): _____

By your signature of this form, you authorize charges to your credit card through Stripe via SimplePractice for services rendered. You have the right to request a paper copy of this document.

I authorize Contrast Counseling, PLLC to charge my credit card through Stripe. I also agree that my credit card can be charged for any session that is not canceled at least 24 hours prior to the scheduled session time.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Contrast Counseling, PLLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.

Authorized signature: _____ Date: _____