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: _____

# Informed Consent, Guidelines, and Policies

*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.

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. Fees charged for cancellations and no shows are not reimbursable by insurance. 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, I am an in-network provider and will submit claims directly to your insurance for you. I 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, I will request that you pay the balance due at that time.

- If you have any other health insurance plan, I am 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 fee is 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.

## Communication and Emergencies

- In order to be accommodating, I may communicate via phone, text, or email at times depending on what is most effective. Please note that emails and text messages are not secure forms of communication and should you choose to utilize those please only do so for non-clinical purposes (i.e., scheduling).
- I always do my best to check and return all forms of communication within 24 business hours. Please note that I 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.

## 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, many exceptions to confidentiality laws. Here are some, but not all, of those exceptions: 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 a valid subpoena is issued. I am 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, as your therapist I may seek consultation 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.

## Legal Services Clause

I do not provide or perform evaluations for custody, visitation, or other forensic matters. It is therefore understood and agreed that I cannot and will not provide any testimony or reports regarding issues of custody, visitation, fitness, or parental responsibility of a parent in any legal or administrative proceeding. If I am contacted by an attorney regarding your treatment or treatment of your child (either at your behest or related to a legal matter you are involved in), please note the following:

- I charge $300 per hour to prepare for and/or attend any legal proceeding and for all court related services including travel time to and from the location of the proceeding.
- Charges for court related services are not covered by insurance.
  - Court related services include talking with attorneys, preparing and reviewing documents, traveling to court and/or deposition venues, and attending depositions and court hearings/trials.
- If my fee is not paid by the court or attorneys, you will be charged for the time I spend responding to legal matters. All fees for legal matters must be paid in advance of the legal proceeding in question.

- You will be charged for any costs I incur responding to attorneys in your case, including but not limited to fees I am charged for legal consultation and representation by my attorney(s).

## 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 initiate the termination process after appropriate discussion with you if I determine that the psychotherapy is not being effectively used or if you are in default on payment. In most cases 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 terminated.

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 and agree to 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

# Informed Consent for Telehealth Consultation

I, _____, hereby consent to engage in teletherapy with Contrast Counseling, PLLC. Teletherapy is a form of psychological service provided via internet technology which can include consultation, treatment, transfer of medical data, telephone conversations, and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. Due to the nature of the technology used, however, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

## Client Rights, Risks, and Responsibilities

I understand that I have the following rights with respect to teletherapy:

1. I, the client, need to be a resident of Illinois and be in the state of Illinois when the session is conducted.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. There are, however, both mandatory and permissive exceptions to confidentiality which are described in the general Informed Consent I received at the start of my treatment with Contrast Counseling, PLLC.
4. There are both benefits and risks of teletherapy services. Treatment delivery via teletherapy may be beneficial due to convenience, distance, or other circumstances. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures, the transmission of my information could be

interrupted by unauthorized persons, and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that teletherapy-based services and care may not be as complete as face-to-face services.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems. If there is a disruption in the service, I am to call my therapist at (872) 205-6176.

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may even get worse.

7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I should call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at (800) 273-TALK (8255) for free 24 hour hotline support.
    a. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

8. I understand that from time to time, we may schedule in-person sessions to "check-in" with one another. My therapist will let me know if teletherapy is no longer the most appropriate form of treatment for me. Together, we will discuss the options of engaging in in-person counseling or referrals to another professional in my location who can provide appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I will not record any telehealth sessions and I can expect my therapist will not record any telehealth sessions either.

11. Sessions will be submitted to insurance but Contrast Counseling, PLLC cannot guarantee sessions will be covered. It is the responsibility of the client to clarify coverage with their individual insurance provider.
    a. In the event that sessions are not covered under the client's plan, the client will be responsible to cover the cost of the session or a teletherapy fee agreed upon with Contrast Counseling, PLLC prior to the start of teletherapy services.

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 and agree to 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: _____