Dr. Kimberly A. Lemke, P.C., Kara Morgan LCSW,
Samantha Mcgann LCSW, Samantha Zurek LCPC,
Susan Rivard (Ryan-Michalak) LCPC
1805 N. Mill Street, Suite B
Naperville, IL 60563

Professional Service Agreement

Dear Patient,

Welcome! I have prepared this letter of agreement for professional services to help you better understand the policies as well as achieve the best possible treatment outcome. Also provided is the Health Insurance Portability and Accountability Act (HIPAA).

Although these documents can be lengthy and involved, it is important that you read them prior to your next appointment. If you still have questions or concerns after reading this material, please feel free to ask. When you acknowledge that you have received this document, it will represent an agreement between us. You may revoke this Agreement at any time in writing. As a patient of Dr. Kimberly A. Lemke, P.C., Kara Morgan LCSW, Samantha Mcgann LCSW, Samantha Zurek LCPC or Susan Rivard (Ryan-Michalak) LCPC, you agree to the following:

1. **Cancellation Policy:** 24-hour notice of cancellation/appointment change is required or the session will be billed at its full rate. Insurance companies do not provide payment for cancelled appointments. This will be your responsibility. Please note that I may use my discretion to terminate services due to multiple missed appointments.

2. **Fee for Service:** All individual therapy sessions are 53 minutes. The fee for the initial Diagnostic Evaluation is $200.00. Subsequent individual therapy, family and consultation sessions are between $185.00-$200. Patients wishing to use insurance benefits are asked to present their insurance information and the pre-negotiated co-pay, percent or deductible in lieu of the full rate at each session. Typically, I ask that you contact your insurance by phone as soon as possible before your scheduled initial visit, so that you have a clear idea of how much your insurance will cover and how much you would be responsible to pay. Payment is expected at the end of each session. Patients selecting to self pay are asked to keep their accounts current and to pay for each session on that session day. Visa, Mastercard, Discover, cash and checks are acceptable forms of payment. Services may be terminated due to non-payment.

3. The patient or guardian is responsible for any owed monies. You are also responsible for any legal fees, costs and/or expenses that result from me collecting past due amounts. I also reserve the right to add a monthly service charge to any outstanding balance. My fee for returned or insufficient fund checks is $25/check. In the unlikely event that your insurance does not cover the services provided, you are responsible for the balance that remains.

4. **Confidentiality:** What is discussed in the confines of the office remains private and confidential within the following requirements of law. First, if a patient or family member reports that there is any possibility of harming themselves or others, including but not limited to physical or sexual abuse, elder abuse, neglect and suicidal or homicidal behavior, the law requires that I make a formal report regarding the situation. Should the need ever arise to make such a report; every effort will be made to involve you in the process and to do so with your participation. My goal is the protection and safety of the patients. Second, if you ask me to bill your insurance, I may be required to share case notes, summaries and other pertinent information about the reasons/diagnosis for which you are seeking therapy. Whenever possible, I limit this information and provide the least amount required to secure benefits. You may request to see this information before it is submitted. Finally, in legal proceedings, if my records are subpoenaed by the court, I may need to provide them. However, I will discuss the possible risks and benefits of a requested release of information before that information is disclosed. In the event that you are involved in legal matters that require my participation, you will be responsible for paying costs

related to my professional time including but not limited to preparation and transportation costs even if I am called to testify by another party. Finally FOID cards may be revoked in certain situations, please make yourself aware of the instances that might affect your FOID card privileges.

5. **Frequency of Treatment:** Typically, patients are asked to be seen on a weekly basis. At times, depending on the severity of symptoms, patients are asked to be seen twice or three times a week if more intensive therapy is needed. Furthermore, in times of crises, it is possible to schedule additional sessions.

6. **Emergency Contact:** Should a mental health emergency arise, please call 911 or contact the nearest hospital emergency room. Once the situation is stabilized, please let me know via phone where you are and what is occurring. I will participate in the emergency intervention as needed and provide whatever case information you ask me to release. Please understand that if this emergency occurs overnight or on a weekend/holiday, it may be the next business day before I am able to respond.

7. **Client responsibilities:** Patients will be asked to work outside of sessions, implementing the strategies and knowledge we discuss together and to be actively involved in your (or your child's) growth and development. You will also be asked to accurately report back on what works and what does not work in achieving the changes and progress you identify as your goal. It is up to you to provide honest effort at helping yourself, your child and your family change and grow. All participants are also responsible for sharing their feelings and concerns, and working through any issues that arise as treatment proceeds. Psychotherapy often involves discussions of unpleasant feelings and events which may result in experiencing sadness, anger, guilt, anxiety and frustration. Although these are uncomfortable feelings, there are many benefits that can arise such as improved relationships, a sense of hopefulness and a lessening of distressing symptoms. Therapy is a process of discovering what will work for each individual patient and family.

8. I reserve the right to modify or change any of the terms of this agreement. Notice will be given to you first and any objections must be made promptly upon receipt of the changes. If no objections arise, I will assume that you accept the changes made.

Thank you for reading this material! If the identified patient is your child, please be sure that your child understands the above material, so that he or she can be more actively involved in the treatment process and take more responsibility for making the treatment work for him or her. If you would like me to elaborate or explain further, please do not hesitate to ask.

I appreciate the opportunity to be a part of your path to emotional health and wellness,

Dr. Kimberly A. Lemke, P.C., Kara Morgan LCSW, Samantha Mcgann LCSW, Susan Rivard (Ryan-Michalak) LCPC and Samantha Zurek LCPC