SamaraCare

5950 S Lincoln Ave (RT 53), Unit W Lisle, IL 60532 (630)-541-8930

We welcome you to our office. We are committed to promoting your personal growth and wellness through our mental health services. Because you may have common questions about office procedures and financial arrangements, we have prepared this information sheet. Please be sure to sign where appropriate and ask your provider if you have any questions about the policies. A copy of the policies will be provided for you at the end of your first session.

Hours and Cancellations: Each therapist keeps his or her own schedule and will arrange appointments with you directly. Psychotherapy sessions vary in length and are set in agreement with each therapist. Most follow up visits with physicians are 20 to 30 minutes. Your therapist and/or physician will discuss their treatment approach with you, as well as its risks and benefits.

Please note that we remind people of follow up appointments for psychiatrist appointments only. This is a courtesy call only, and it remains your responsibility to keep the appointment even in the event that you do not receive the call. We do not remind for any therapy appointments. If it becomes impossible for you to keep an appointment, it is important that you call us as soon as possible to cancel your reserved time. An appointment that you cannot keep must be cancelled no less than 24 hours before the scheduled time. **Appointments that have not been appropriately cancelled will be charged the full regular session fee. Please note that our answering service logs call times should a cancellation be required over the weekend. This fee is your responsibility as insurance companies will not reimburse you, nor can they be billed for missed appointments. It is also your responsibility to inform any non present paying party of this policy.** I certify that I have read the above statement about cancellations and agree to abide by these terms. I have had opportunity to ask and have answered any questions regarding this policy.

_____ _____ _____

Responsible party Date Number for reminder call

Phone Calls: Our general policy is to leave only our name and phone number when phone calls are returned. Please indicate your consent for our office to leave treatment information: this includes appointment changes, medication changes, prescription information, account information, etc.

☐ I authorize SamaraCare to leave treatment information on answering machines and voice mail

☐ I do not authorize SamaraCare to leave treatment information on answering machines and voice mail

Fees and Insurance Charges for sessions vary according to type of service provided and are consistent with standard treatment fees in the community. PAYMENT IS REQUESTED AT THE TIME OF SERVICE. Please make checks payable to Wellspring Clinical Associates (SAMARACARE). Many insurance plans will reimburse you for some or all charges for psychotherapy. If you are eligible for reimbursement under your plan, you may attach the receipt from each session to your insurance claim form when you submit the claim. Any specific questions about your bill may be discussed with your therapist or our billing department. If Wellspring Clinical Associates is contracted with your insurance company, they will submit claims on your behalf. You will be responsible for any co-payment or coinsurance amounts at the time of service. Please check your benefits with your insurance company prior to your appointments. **Please note that payments for any non-covered diagnoses and/or services are your responsibility. In addition, we will request that any outstanding balance be paid prior to seeing your provider on follow up.**

_____ If SAMARACARE is submitting claims to my insurance company; I authorize them to receive payment of medical benefits directly, if they accept assignment.

Guardians or Parents of Minor Patients Wellspring clinical associates treats patients under the age of 18. Those patients aged 12 to 18 have certain extra rights granted them, including the right to consent to release of their medical records. By signing the office

policies, you give your consent to treatment of your minor child, assuming you have not otherwise explicitly refused treatment. You also understand that your child (if over the age of 12) has the right to consent to release of their records.

Non-custodial and divorced parents: Wellspring Clinical Associates does everything possible to involve all parties as appropriate in the treatment of their child. In order to best assist you in this regard, any minor child of divorced parents should have on file in our office a copy of the divorce and custody decree. In situations of divorce it will be up to the parents to determine who will be responsible for payment of missed sessions. All sessions at SAMARACARE are understood to be therapeutic only and not for any legal purposes related to custody or other legal determinations unless otherwise explicitly agreed to by all parties.

Out of session calls and coordination of care: Our providers are commonly asked to complete forms, have telephone conferences and submit letters for purposes of appropriate school or community intervention. Any form completed outside of regular session hours will require a nominal convenience fee. Letters often require extensive effort on the part of providers, in terms of review of previous records and compilation of opinions and recommendations. Accordingly, a charge applies for completion of these documents. Cost varies depending on amount of time spent by your provider. Please discuss this with your provider if you have questions. While therapy sessions are the primary place for care to be provided, we understand that questions may arise between sessions. Any provided services (such as telephone calls) outside of regularly scheduled session time may incur additional fees that are usually not covered by insurance. **I certify that I have read the above statement about fees and agree to abide by these terms. I have had opportunity to ask and have answered any questions regarding this policy.**

_____ _____

Responsible party Date

Prescription refills: Our policy is to fill all prescriptions during your regularly scheduled face to face appointments with your physician. Requests for refills over the telephone will be called into your pharmacy Monday through Thursday from 9:00 am to 3:00 pm. Please note that if you call for a refill request after this time, it will not be honored until the next business day. Some prescriptions cannot be called into pharmacies, and cannot have refills. It is your responsibility to allow adequate time for new prescriptions of this type to be processed. Please allow up to 48 hours to process your request for a refill. ABSOLUTELY NO REFILL REQUESTS WILL BE HONORED OVER WEEKENDS. **Outstanding balances on accounts must be addressed prior to provision of refills.**

Emergencies: In the event of an urgent matter, you may leave a message for your therapist on our 24-hour answering service. You should call 911 or proceed to the nearest emergency room for emergencies.

Termination of Care: If you have not been seen in the office for 14 months as a minor, or 18 months as an adult, SAMARACARE may assume you have transferred your care elsewhere or no longer desire treatment, and may close your case in the office. We may send you a letter reflecting our termination process at that time. We may also decide to end care for other reasons, including but not limited to goodness of fit with therapist or problems with compliance. In both cases, SAMARACARE will provide you with a letter of referral to other providers, and will transfer records with an appropriate release to your new provider.

Confidentiality:

_____I acknowledge receipt of the Notice of Privacy Practices, detailing information about how the practice may use and disclose my confidential information. I understand that SAMARACARE keeps an integrated electronic medical record with full access to anyone at SAMARACARE involved in my care.

_____ I hereby give my consent for SAMARACARE to use or disclose, for the purposes of carrying out the treatment, payment, or healthcare operations, confidential information contained in the medical record of the patient listed below. I further understand that this consent is valid until revoked in writing by me.

All items have been fully explained to me; I understand them and take full responsibility for their contents.

Patient Name _____

Patient/Responsible Party Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

(REVISED September 26, 2014)