LIMITS OF CONFIDENTIALITY

The Law protects the privacy of communication between a client and a therapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA.

There are some situations in which a mental health professional is legally obligated to take actions to protect others from harm and may have to reveal some information about a client's treatment.

- Disclosures required by health insurers or to collect overdue fees.
- If a client threatens to harm himself/herself, the mental health professional may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
- If there is reason to believe that abuse of a child, disabled adult, or elder person has occurred, the law requires that a report be filed with DCFS.
- If a client is involved in a court proceeding and a request is made for information concerning professional services.
- If a government agency is requesting the information for health oversight activities.
- If it is determined that a client presents a serious danger of violence to another, actions may include notifying the potential victim, and/or contacting the police.
- Patients under 18 years of age, who are not emancipated, and their parents should be aware that the law allows parents to examine their child's treatment records unless we believe that doing so would endanger the child or we (patient, therapist, and parents) agree to do otherwise.
- Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature	Date
Client (Spouse) Signature	Date
Guardian Signature (if client is a minor)	Date

CANCELLATION POLICY

Each therapy appointment is traditionally a 45- 50-minute hour, unless specially arranged by the therapist. Once an appointment is scheduled, ***it is your responsibility to keep track of the dates and times of your appointments***. If you must cancel your appointment or need to reschedule, please phone the office at least **24 hours in advance** of your scheduled appointment. **A late cancellation fee will be billed to you for the time that was reserved for your appointment.** This fee is $100 and is not covered by insurance companies. We reserve the right to terminate treatment with a client for failure to show up at two or more appointments. In cases of emergencies and/or hospitalizations, please discuss concerns with your therapist, as reducing/waiving this fee is at the discretion of the individual therapist.

Professional Fees

The fees for services vary. Please speak to your individual therapist for details.

We ask that your account be kept current and payments be made at the conclusion of each session. We accept cash, check, Visa or MasterCard. If your check is returned, you will be responsible to pay the original amount due plus a $35 processing fee. Should the fee not be paid for two or more sessions, no further sessions will be scheduled until the balance is paid and/or payment arrangements have been made with your counselor. At the conclusions of treatment, all outstanding fees must be paid upon termination.

Insurance

Your counselor may or may not be a provider for a managed care company. Please check with the counselor to determine if using your insurance is an option, as not all of our providers are on insurance panels.

Verifying and submitting a claim for insurance benefits is your responsibility. If eligible, your therapist will provide you with the necessary information to submit these claims.

Your signature below indicates that you have read this agreement and consent to treatment by our providers under these terms and conditions. This agreement also serves as an acknowledgement that you understand that HIPPA privacy guidelines. If you would like a copy of this agreement, we will be glad to copy the signed form for you.

_____	_____
Client Signature	Date
_____	_____
Client (Spouse) Signature	Date
_____	_____
Guardian Signature (if client is a minor)	Date