Rooted Mind
COUNSELING CENTER

1247 Milwaukee Ave. Suite# 208 Glenview, IL. 60025~224.257.4190

Practice Policies, Informed Consent, and Financial Agreement

Fees for Professional Services:

Payment is due at the time services are rendered.

I agree to pay $_____for each psychotherapy session (50 minutes).

I agree to pay $30 for each returned check and for any late payment 45 days past due until paid in full.

Payment can be made in the form of cash, check or any major credit card. Please notify Rooted Mind Counseling Center, LLC. (RMCC) if you would like a receipt. We require that you keep a credit card on file. If you wish to seek reimbursement from an out-of-network insurance provider, we will provide a receipt/statement indicating sessions paid.

Cancellation Policy:

All cancellations require a 24 hour notice. Please note that late cancellations or missed appointments can not be offered to another client, therefore **you will be charged a fee of $100 without the proper 24 hour notice**. In the event of an emergency, cancellation/missed appointment fees will not apply. On the other hand, if the Rooted Mind Counseling Center provider misses or cancels an appointment without 24 hour notice, you will be credited one session per cancellation. Please arrive to your scheduled appointment on time. . If you have missed three consecutive appointments (without contact or notification), we will accept this as notice that you wish to terminate this agreement and discontinue therapy.

Communication:

We are available by telephone or e-mail and will typically respond within the next business day. Telephone and e-mail will only be used for administrative purposes (e.g., confirming appointments via e-mail or voicemail messages, sending receipts, invoices, and other forms, etc.). We will do our best to ensure your confidentially through e-mail, phone, or fax. However, due to viruses, hackers, etc., please note that no e-mail, phone, or fax correspondence is guaranteed to be confidential. Clinical matters will not be discussed via e-mail or telephone and you are encouraged to set up an appointment in order to discuss such concerns. Additionally, in order to maintain the highest ethical and professional standards, our association will be limited to the traditional therapist and client relationship. Finally, **if you are experiencing a life-threatening emergency, please call 911 or go to your nearest hospital emergency room.**

Confidentiality and Limits to Confidentiality:

The contents of material disclosed to us in a clinical therapy session are covered by the law as private information and will not be disclosed without your written consent. We respect the privacy of the information you provide us and we abide by ethical and legal requirements of confidentiality and privacy of records. We will use confidential information for the purpose of treatment, payment, and health care operations. All uses, disclosures of, or requests for protected health information will be limited to the minimum amount necessary to accomplish the stated purpose. Professional judgment will determine the amount of information to be released. Without a written release from you, I will keep everything you share with me confidential except if you pose a danger to yourself or others, or I am required by law to breach confidentiality or in response to a court order for me to release information.

(over)

The following are legal exceptions to your rights to confidentiality. I will inform you in the event these need to be put into effect.

1. **If I have good reason to believe that you will harm another person, I must attempt to inform that person and warn them of your intentions. I must also contact the police and ask them to protect your intended victim.**
2. **If I have good reason to believe that you are abusing or neglecting a child or vulnerable adult, or if you give me information about someone else who is doing this, I must inform Child and/or Adult Protective Services within 48 hours.**
3. **If I believe that you are in imminent danger of harming yourself, I may legally break confidentiality and call the police. Please note, I would explore all other options before taking this step. If at that point, you are unwilling to take steps to guarantee your safety, I would call the police.**

The Therapy Process

Therapy is a collaboration process between client and therapist. We are a team. The initial evaluation/assessment will evaluate your needs and determine the type of services necessary. During this time, both you and the RMCC clinician can decide if he/she is the best clinician to provide the services you need in order to meet your treatment goals. The initial evaluation generally requires two to three sessions. Ongoing therapy typically involves weekly individual sessions that last approximately 50 minutes unless other arrangements have been made. The length of therapy varies and ultimately depends upon the progress being made. The results of therapy cannot be predicted with certainty but depend in large part on your effort and engagement in the process. The benefit of therapy is that you may find relief from your primary concern(s). Therapy can also result in improved mood, enhanced coping skills, better relationships, and increased self-esteem. One risk of therapy is that while improving your emotional and mental health, you may (by your own volition) find yourself making important life decisions that might affect or alter your current relationships. In addition, you may experience some uncomfortable emotions. You have the right to stop treatment at any time. Alternative options may include a referral to another mental health professional and/or health care provider (e.g., psychiatrist, medical doctor) or, in contrast, seeking no treatment.

You agree to receive mental and behavioral treatment from a Rooted Mind Counseling Center, LLC. professional. You also understand that no specific promises were made regarding the outcome of treatment or the number of sessions necessary. Finally, any questions you may have regarding the treatment process can be discussed at any time.

No Court Testimony:

If you ever become involved in a divorce or custody dispute, or any other legal proceedings, neither you, nor your attorney(s), nor anyone else acting on your behalf will call the therapist to testify in court or any other proceedings. Nor will psychotherapy records be requested. Your signature below indicates that you agree with this provision. If RMCC receives a subpoena in a court related matter, you agree to pay all our court costs and attorneys fees in refusing to respond.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices:

Your signature indicates that you received and reviewed the HIPPA Notice of Privacy Practices Form.

I, _____, certify that I have read, understand, and agree to all the above conditions and policies. I acknowledge that payment is due at the time of service. If my insurance company does not reimburse the contracted amount, I am responsible for payment. If collection through collection agencies or other legal proceedings becomes necessary, I will be obligated to pay reasonable attorney fees and costs incurred in collection. I agree that my protected health information may be disclosed for the purpose of treatment, payment, and health care operations. I consent to treatment and have read and understand the HIPPA Notice of Privacy Practices. I acknowledge that any and all personal and clinical information provided to RMCC is true and accurate to the best of my knowledge. In addition, I have had an opportunity to ask clarification regarding the stated policies.

Client Signature:_____ Date: _____/_____/_____

Clinician Signature: _____ Date:_____/_____/_____