**OUTPATIENT SERVICES CONTRACT**

Welcome to the **North Suburban Center for Anxiety, LLC**! Since this is your first visit to our practice, we hope that what is written here can answer some of your questions as you seek therapy. Please let us know if you want clarification on any of the topics discussed in this outpatient service contract, or if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this outpatient service contract.

**Psychotherapy Services**

Treatment: At the North Suburban Center for Anxiety, LLC, we provide individual counseling for children, adolescents, and adults. We specialize in using Cognitive Behavior Therapy (CBT) to treat anxiety, OCD, depression, and related disorders. Examples of cognitive behavioral interventions may include (and are not limited to): Exposure therapy, exposure and response prevention, cognitive restructuring, behavioral activation, and additional cognitive and behavioral interventions.

Initial Assessment: The first one to two sessions consist of an initial comprehensive assessment. During this time, the therapist will meet with the client to review their psychiatric history, assess current functioning, and administer assessment measures. The comprehensive assessment is then used to create a customized treatment plan.

Your Treatment Plan: A client’s treatment plan may include one or a combination of the following: Individual cognitive behavior therapy, exposure therapy (in and outside of the office), home visits, referrals to a psychiatrist for medication evaluation, or referrals to a physician for medical evaluation. Additionally, consultation and/or collaboration with family members, outside provider(s), and/or school personnel may be necessary as part of an effective treatment plan.

Length and Frequency of Sessions: All sessions are 45 minutes. However, a longer session may be scheduled, if needed. When this occurs, sessions are prorated accordingly. Typically, sessions are set for once per week, but this can vary based on what is most appropriate for the client.

Collaboration: Your therapist may occasionally find it helpful to consult with other professionals about a case. During consultation, the therapist will give information only to the extent necessary and will make every effort to avoid revealing the identity of the client. The professionals with whom are consulted have the same confidentiality obligations as your therapist.

Benefits and Risks: Therapy can be extremely helpful and fulfilling, and it takes work both in and out of sessions to be most effective. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. There are benefits and risks to therapy. Potential benefits include increased healthy habits, improved mood, and decreased anxiety. Some potential risks include increased uncomfortable emotions as you self-explore. Although there are many benefits to therapy, there is no guarantee of positive or intended results.

If, at any point during psychotherapy, your therapist assesses that s/he is not effective in helping you reach your therapeutic goals or noncompliance with recommendations becomes an issue, your therapist will make efforts to discuss this with you to determine the barriers to treatment compliance. At times, treatment noncompliance or ineffectiveness may necessitate termination of therapy services. In such a case, if appropriate and/or necessary, your therapist would provide you with referrals for other mental health professionals. Other factors that may result in termination of therapy include violence or threats towards the therapist or refusal to pay for services after a reasonable time and attempts to resolve the issue.

Between Session Availability and Emergencies: It is the practice’s mission that individuals, with the help of their provider, learn how to use their therapeutic skills independently. Therefore, we encourage clients to attempt practice of learned treatment strategies prior to contacting their therapist for support. However, we also encourage between-session consultations if this additional contact would further therapeutic progress. We will respond to between-session phone calls within 24 hours, with the exception of weekends and holidays. All messages left on a weekend will be returned on Monday.

We are not designed to be on-call for emergencies or provide ongoing crisis management. If you or your child are in a mental health emergency and require immediate assistance, please call 911 or go to the nearest hospital emergency room and leave a voicemail message for your therapist to notify them of the emergency.

**Financial and Payment Policies**

Insurance

The North Suburban Center for Anxiety, LLC does not participate in any insurance networks. This allows us to make optimal treatment decisions regarding length and type of therapy without the limitations imposed by third party payers. We are committed to providing you with the best, most effective treatment available. Ultimately, we believe that our method of cost-effective, results-oriented therapy will result in shorter treatment and lower out-of-pocket costs for you.

Clients will be given a “super bill” with the proper code numbers for diagnostic category and type of service provided, as well as any additional necessary information. You may submit this to your insurance company or save it for your financial records. You may then be reimbursed directly by your insurance company per the terms of your policy. Our licensed therapists are considered “Out of Network Providers,” as we are not participating providers of any insurance plans. While many of our clients are successful in receiving reimbursement for a portion of the service rendered, reimbursement is considered a matter between you and your insurance company. Please contact your insurance company directly for question about coverage. Occasionally your insurance company may require us to contact them to discuss your treatment and progress. We are glad to respond to brief requests for information. In the event that extensive information or written reports are requested, we will notify you.

Rates

* The fee for a 45-minute appointment and corresponding documentation time is $165
* The fee for an initial 60-minute clinical evaluation and corresponding documentation time is $215
* In addition to your regular appointments, your care may require additional professional services. The same hourly rate will apply to these services, although we will break down the hourly cost if we work for periods of less than one hour. These other services may include: report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, travel time to/from any out of office appointment, and the time spent performing any other services you may request of your therapist.

Means of Payment

Payment is expected at time of service. We accept cash, check, or credit card. We require that a credit card is kept on file for billing purposes.

Cancelation/No-show**:** We require at least 24 hours advance notice of a session cancellation. If less than 24-hours notice is given, your therapist may charge you the full agreed upon rate of services. Please be advised that insurance companies do not reimburse for canceled appointments.

Divorce/Separation of Parents/Legal Guardians**:** In the case of a divorce or separation, the party responsible for the account balance is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Late Payment: An account that has not been paid for more than 60 days without payment arrangements being made will be eligible for collection proceedings. This may involve legal action, hiring a collection agency, or going through small claims court. If legal action or collection assistance is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a client’s treatment is his or her name, the nature of services provided, and the amount due.

**Social Media Policy**

In order to maintain your confidentiality and our respective privacy, therapists at the North Suburban Center for Anxiety, LLC do not interact with current or former clients on social networking websites.  We do not accept or respond to friend or contact requests from current of former clients on any social networking sites.

We will not solicit testimonials, ratings or grades from clients on websites or through any means. Although it is your decision, we encourage you to avoid writing testimonials about the practice on any websites, in order to maintain your privacy.  We will not respond to testimonials, ratings, or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns to the therapy session so it can be addressed directly.

We are happy to accept emails and text messages for scheduling, canceling, and changing appointments only. Please do not contact your therapist through text messages or email. Please do not include personal information about your therapy in emails or text messages, as email and text messages are not completely secure and confidential.  If there is information that you believe needs to be shared prior to your next appointment, call your therapist and arrange a time to speak by telephone.  Emails are typically returned within 1-2 business days, and should therefore never be used in the case of an emergency. We do keep all emails sent to and received from clients as part of the therapy record.

**Professional Records**

Both law and the standards of our profession require that we keep appropriate treatment records.  If we receive a request for information about you, you must authorize in writing that you want the requested information released.

**Confidentiality**

In general, the confidentiality of all communications between a client and a therapist is protected by law, and your therapist can only release information to others with your written permission.   However, there are a number of exceptions, some of which are indicated below, in which your therapist may be required by law to break confidentiality. *More information is provided about this in your HIPAA statement*

In judicial proceedings, if a judge orders records released to the courts, your therapist may have to release the records. In addition, your therapist is ethically and legally required to take action to protect others from harm, even if taking this action means s/he reveals information about you. For example, if your therapist believes that a client is at imminent risk of threatening serious bodily harm to her/himself or to another person, the therapist may be required to contact the appropriate authorities or individuals (e.g., notifying the potential victim, contacting the police, facilitating hospitalization of the client, and/or contacting family/significant others who can provide protection). If your therapist believes that a child, elderly person, or disabled person is being abused or neglected, s/he may be mandated to report this to the appropriate state agency

Your therapist will make reasonable effort to discuss any need to disclose confidential information about you, and will be happy to answer any questions you have about the exceptions to confidentiality.

This written summary of exceptions to confidentiality should prove helpful in informing you about potential problems. However, you may consider discussing these exceptions with separate legal counsel, as the laws governing confidentiality are quite complex and are subject to change.

**Minors**

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child’s treatment records. When children between the ages of 12 and 18 are seen alone, the content of these sessions is kept confidential, between therapist and child.  Parents of children between 12 and 18 years of age cannot copy and inspect their child’s records unless their child consents or unless the therapist finds there is no compelling reason for denying them access to those records.  Parents of children between 12 and 18 years of age are entitled to information concerning their child’s current physical and mental condition, diagnosis, treatment needs, services provided and services needed.  If the therapist believes that the child is at imminent risk of harming himself/herself or others, the therapist may notify the parents of this concern.  Before giving parents any information, the therapist will discuss the matter with the child, if possible, and the therapist will try to handle any objections the child may have with what the therapist is prepared to discuss with the parents. **Our policy is that both parents be notified that their child is in therapy and both parents provide consent in writing to therapy for the child.**

**Legal and Court Related Services**

We do not provide or perform evaluations for custody, visitation, or other forensic matters.  Therefore, it is understood and agreed that your therapist cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal or administrative proceed.

If your therapist is 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:

* We charge $400 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.  Fees for legal and court related services must be paid prior to the scheduled court hearing or deposition.  Charges for court related services are not covered by insurance.
* Court related services include: talking with attorneys, preparing and reviewing documents, traveling to court or deposition venue, attending depositions and court hearings/trials.
* If our fee is not paid by the court or attorneys, you will be charged for the time we 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 we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

**FOID Mental Health Reporting Requirement Act**

As per the Illinois Firearm Concealed and Carry Act, your therapist is required to notify the Department of Human Services (DHS) within 24 hours of determining a person to be a Clear and Present Danger to themselves or others or Intellectually Disabled, regardless of the provider’s practice, the person’s age, or any other diagnosis of the person.

**Questions**

If during the course of therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

**A Final Word**

The counseling relationship is a very personal and individualized partnership.  We want to know what you find helpful and what, if anything, may be getting in the way.  We want you to feel free to share with us what we can do to help.

Please ask before signing below if you have any questions about psychotherapy or our office policies.  Your signature indicates that you have read this Outpatient Services Contract and agree to enter therapy under these conditions.  Your signature below indicates that you are making an informed choice to consent to therapy and understand and accept the terms of this agreement.

Client's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

Parent 1 or Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

(Parent or guardian if under age 18)

Parent 2 or Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

(Parent or guardian if under age 18)

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_