Client-Therapist Services Agreement

Client Name: _____ Date of Birth: _____ Pronouns:_____

Preferred Name: _____ School & Grade: (if applicable) _____

Gender: ☐ M ☐ F ☐ Nonbinary ☐ Trans ☐ Prefer not to answer ☐ Other _____

CONSENT FOR TREATMENT:

_____ hereinafter "Therapist", provides evaluation, assessment, and/or psychotherapy to individuals. The therapist will generally develop a comprehensive treatment plan which will be modified regularly depending on the needs and progress of services provided. Should a higher level of care be indicated, the therapist will work with you to achieve the most appropriate level of care and, if appropriate, refer you or your child to a program or facility that is able to provide you/your child with a level of service appropriate to your needs.

The therapy process may involve processing life experiences, which may evoke positive or negative feelings. There is no way to estimate the duration of or quantify results as the therapeutic process is dynamic and unique to the issues, needs, and types of treatment that is most effective to each individual. Therapy, by its nature, requires continuous adjustments to the treatment plan and modalities of treatment. There is a small risk that your condition may worsen during treatment prior to it getting better. If at any point you are unhappy about the progress, process, or outcome of your treatment, please discuss this with your therapist so that attempts can be made to resolve any difficulties and/or arrive at a treatment plan that better meets your needs.

By signing at the end of this document, you consent to participate in mental health services/therapy. You also acknowledge that clients who participate in mental health services must explore and analyze many personal, family, friendships and other interpersonal experiences and behaviors. Therapy will often assist in improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy requires commitment, effort, and consistent participation on your part to secure the best results. Successful therapy requires your involvement in the process and is most successful if you commit to being honest with your feelings and being willing to look at thoughts, feelings and/or behaviors. Successful therapy is not a one-size-fits-all proposition. Often various treatment options such as individual psychotherapy, group, couple, family therapies, and/or, in certain circumstances, the referral to a psychiatrist for the evaluation and/or management of medication may be helpful.

TELETHERAPY (if applicable):

I further hereby consent to participate in teletherapy as part of my services, if applicable. I understand that teletherapy the provision of mental health services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to teletherapy:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2. I understand that there are risks and consequences associated with teletherapy, including but not limited to, the following:
    - Risks to confidentiality: Because teletherapy sessions take place outside of the therapist's private office, I understand that there is potential for other people to overhear sessions if I'm not in a private place during the session.

    - Issues related to technology: There are many ways that technology issues might impact teletherapy, including, but not limited to internet issues during a session, individuals having access to our private conversation, and/or stored data could be accessed by unauthorized people or companies. I understand that my therapist will use updated encryption methods, firewalls, and back-up systems to help keep my information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others.

    - Crisis management and intervention: Before engaging in teletherapy, my therapist and I will develop an emergency response plan to address potential crisis situations that may arise during the course of our teletherapy work. If the session is interrupted for any reason and **I am having a clinical emergency,** I understand that I must call 911 or go to my nearest emergency room prior to calling my therapist back.

3. I understand that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that the privacy laws that protect the confidentiality of my protected health information ("PHI") also apply to teletherapy health unless an exception to confidentiality applies.

5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy is not appropriate and a higher level of care is required.

6. I understand that during a teletherapy health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, my therapist will disconnect from the session and will wait two (2) minutes and then re-contact with me via the teletherapy platform on which we agreed to conduct therapy. If I do not receive a call back within two (2) minutes, then I will call/text my therapist to discuss possible alternatives.

COMMUNICATION:

I authorize the Therapist to communicate with me in the following ways: (Please Check & Initial)

□ ____Call / □_____ Leave a message - Cell phone _____

□_____Call / □_____ Leave a message - Home phone _____

□_____Call / □_____ Leave a message - Office phone _____

□_____ Communicate by Email: _____

□_____ Communicate by Text: _____

EMERGENCY PROTOCOLS:

I agree to provide my location to my therapist in case of an emergency. My therapist will also require that I provide the contact information for an emergency contact person. This person will only be contacted in a life-threatening emergency when it is necessary for them to go to your location or take you to the hospital.

EMERGENCY CONTACT: _____

PHONE NUMBER: _____

TELEPHONE AND EMERGENCY PROCEDURES:

If it is necessary to contact the therapist between sessions for a purpose other than scheduling/payment and you are not able to reach him/her directly, the therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays. Due to your therapist's work schedule, your therapist is often not immediately available by telephone. While your therapist may be in the office, your therapist is generally in session and unable to answer the phone immediately. If your therapist will be unavailable for an extended period of time, the therapist will provide a covering therapist's contact information on their voicemail message or provide you with the name in session. The therapist is unable to guarantee continuous 24-hour crisis services. In the event of an emergency or a life-threatening situation, go to the nearest local emergency room or call 911.

CONFIDENTIALITY:

Your therapist views a client's right to privacy as not only their legal duty, but as an essential part of any therapeutic relationship. Without written authorization, your therapist will neither confirm nor deny that a client is even being seen in the practice. This includes, but is not limited to, family members, health professionals, and employers. Therapists are legally required to make an exception to their commitment to privacy when a client is in danger (i.e. abuse, domestic violence, inability to commit to safety), medical emergencies, court orders, to prevent a crime or harm to others, and health oversight agencies (i.e audits); however, they will always disclose to the client when these exceptions are required. For further information about these exceptions, please review the Notice of Privacy Practices (HIPAA) form found in the portal or in the office.

Please be advised that questions regarding billing matters will only be discussed with the client or responsible party. In the event of a request for the transfer of records to another health professional, the records will be forwarded directly to that person upon completion of a release of information form by the client. If utilizing insurance, the client must authorize a release of the information necessary for the therapist and billing specialist to file claims and determine/assign benefits with their insurance company and the corresponding insurance agents.

□_____ I understand and have been offered a copy of the Privacy Notice as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the notice I do not understand **(Please check and initial)**

INSURANCE/FEES/PAYMENTS:

- Private pay sessions are charged at a rate of $200 for the initial 50-minute session and at a rate of $175 for subsequent 50-minute sessions.
- Sliding scale fees are determined by each individual therapist.

If you are covered by an insurance company with whom the therapist is an in-network provider, the therapist must comply with and accept payment pursuant to the contract that both they and you have with the insurance company. The rates for in-network insurance companies may not be negotiated as they are fixed by contract. Even you have insurance coverage, you or your responsible party are legally responsible for the payment of services including co-pays, contract deductibles and any amount not paid by insurance with the exception of provider contracted reductions. If you have a significant change in your financial situation, you must disclose this information to their therapist so that possible solutions can be discussed.

If the therapist is an in-network provider of your insurance network, the therapist will bill your insurance company directly as a convenience offered to you. You must keep the therapist informed immediately regarding any changes to your insurance and will be responsible for the payment of any co-payments or deductibles associated with your policy at the time of the session as well as any uncovered services as identified above. Since the responsibility of full payment of all fees is on the client, it is important to confirm exactly what mental health services your insurance policy covers. If you must obtain authorization from your primary care physician or your insurance company prior to your first office visit, it is your obligation to do so unless agreed upon by the therapist and billing specialist. Any secondary insurance claim filing is the responsibility of the client.

Twenty-four (24) hours minimum notice is required for a cancellation of a session or you can be charged the full session fee. Please be aware that your insurance will not accept claims for cancellation/missed session fees.

In order for your therapist to offer you our highest quality of services, all balances over 90 days must be paid in full or a payment plan must be established before scheduling future appointments. If charges are unpaid after 120 days, accounts may be turned over to a collection agency with any information that may be required for collection of the debt. Should a delinquent account be turned over to a collection agency or attorney, the client or responsible party will be responsible for court costs, attorney fees and collection fees. If you think you may have trouble paying your bill on time, please discuss this with your therapist so that a solution can be determined.

Please check & initial one of the two options below.

□ _____ I authorize the therapist to act as my agent in helping me to obtain payment from my healthcare provider. I also authorize the release of necessary information to the insurance company for the pursuit of payment. If my healthcare company changes, it is my responsibility to let the therapist know immediately. If not, I will be responsible for payment of the balance on my account. I authorize insurance payments to be assigned directly to the therapist.

□ _____ I do not authorize the therapist to contact my healthcare provider for third party payment. I understand that if I have insurance and have decided not to process any claims through my insurance company for any reason, I am personally obligated to pay the private pay rates and waive any rights to a reimbursement rate as provided under my insurance policy. If at any time I choose to seek reimbursement for my services through any insurance policy, I will notify the therapist and amend this section to provide for reimbursement for any prospective appointments and waive my rights to any prior completed appointments and costs.

SESSIONS/CANCELLATION POLICY:

Therapy sessions are generally 50 minutes long, although the precise length may vary. Please arrive on time as your session length cannot be extended when you arrive after your scheduled start time. The number and frequency of sessions are determined based on what is clinically necessary and may be affected by insurance coverage and client/therapist availability. Ultimately, regular and consistent sessions are necessary for effective therapy.

Any cancellation or rescheduling of an appointment must be done at least 24 hours prior to your appointment by calling and leaving a voice mail message with your therapist. Failure to cancel without at least 24 hours' notice will require that you pay the **full fee** for the missed session and will **not** be covered by your insurance company. It is important for you to understand that your therapist has set aside your appointment time for you and cannot simply do other work if you are unable to attend.

DIVORCE/SEPARATION AGREEMENT:

When the therapist provides services to individuals, children, or adults of families experiencing separation or divorce, the purpose is to aid the patient whom the therapist is seeing through the challenges inherent with these trying circumstances and not to become a witness in the proceedings. Your therapist will not participate in or provide opinion in any custody arrangements, visitation schedules, or other family court matters

TERMINATION OF THERAPY:

The length of your treatment and the timing of the eventual termination of your treatment depends on the specifics of your treatment plan and the progress you achieve. It is a good idea to plan for your termination in collaboration with the therapist. Except in the case of emergency or should your therapist not be able to contact you, your therapist will discuss a plan for termination with you as you approach the completion of your treatment goals. If you or the therapist determine you are not benefitting from treatment, either you or the therapist may elect to initiate a discussion of treatment alternatives and/or notify you of intention to terminate. In the unfortunate circumstance that you have an outstanding balance with the therapist and you do not enter into an agreement to resolve the payment of the outstanding balance with the therapist, the therapist will have to initiate termination. If possible, the therapist will attempt to provide you with referral resources if termination occurs and all treatment goals are not met.

l have read, understand and agree to the above clinical and financial policies. I hereby agree to assign to my therapist the benefits to which I am entitled to under any health insurance plan. I give my consent to my therapist to provide evaluation, treatment and/or other services that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and I understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss my reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

Client Name (Printed) _____ Date: _____

Client Signature:_____

Intake: 312-924-1884 | Office: 312-339-9832
www.DrShantelleAndAssociates.com | DrShantelle@whiteheadselfcare.com

NAPERVILLE
552 S Washington St,

CLARENDON HILLS
136 Burlington Ave

BOLINGBROOK
550 E. Boughton Rd., #205

GLEN ELLYN
800 Roosevelt Rd, Bldg B

FOR MINORS UNDER 18 YEARS OLD (If Applicable)

I certify that I am the Parent or Legal Guardian and have legal authority to consent to mental health services for the above-named client and accept financial responsibilities for any services provided by the therapist. I, hereby, give my authorization and consent for the client to receive outpatient treatment from the therapist.

I hereby consent to the treatment of the above identified patient subject to the terms outlined hereinabove:

Parent/Guardian Name: _____ Birthdate: _____

Address: _____ City, State., Zip_____

Phone (C) _____ Phone (W) _____ Email: _____

□ ***Check if legally designated to make medical decisions and provide therapist with copy of parenting agreement***

Parent/Guardian Name: _____ Birthdate:_____

Address: _____ City, State., Zip_____

Phone (C) _____ Phone (W) _____ Email: _____

Parent/Guardian signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

GUARANTOR

I, as guarantor/person assuming financial responsibility, understand that I will be unconditionally responsible for the payment of any uncovered services, costs, and expenses provided to the above identified client by their therapist(s). It is understood that as guarantor of payment, I agree that prior to discontinuance of my unconditional responsibility to pay for charges contemplated in this document, I shall give no less than 90 days notice of my intent to discontinue to the therapist in writing.

Guarantor's Name: _____Birthdate: _____

□ ***Check if same as above***

Address: _____ City, State., Zip_____

Phone (C) _____ Phone (W) _____ Email: _____

Guarantor's Signature: _____ Date: _____