Informed Consent, Confidentiality and Cancellation Policy

Welcome and thank you for allowing me to work with you on your path toward health and wellness. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an extension of the initial, verbal agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular challenges you wish to address. There are many different methods I may use to deal with these challenges. Psychotherapy calls for a very active effort on your part. In order for the therapy to be successful, you will need to work on things we talk about both during and in between our sessions.

Psychotherapy can have benefits and risks. Therapy often leads to reduction of feelings of distress, more satisfying relationships, resolution of specific problems, and an increase in positive feelings and overall happiness and life satisfaction. Growth nearly always brings change, and sometimes change (even positive change) causes stress. Potential risks of counseling involve recalling unpleasant aspects of your life that may bring up uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. This is a natural part of the process and one that we will work together to address. Because of the complexity of human behavior, there are no guarantees that you will feel better or that your problem(s) will get resolved. If you have any concerns about your progress or the results of your counseling experience, please talk to me during our work together.

GENERAL STRUCTURE OF COUNSELING SESSIONS

We will meet initially to discuss the nature of your therapy needs and to determine approximate frequency of sessions necessary to accommodate those needs. Sessions are usually scheduled for 50-minute periods. Length or frequency of sessions can be increased or decreased to reflect your counseling needs. I do short-term and long-term therapy based on my assessment of your needs and objectives. I may assist you in obtaining resources in the community. Sessions are held in my office in Evanston. There may be an occasion where a client cannot come in, and may wish to have a phone or Skype session. When this need arises, we can discuss this.

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide at least 24 hours advance cancellation or unless we both agree that you were unable to attend due to circumstances beyond your control. I will try to find another time to reschedule the appointment. If canceling/ and or missing appointments becomes a chronic problem, it will be necessary to reevaluate the commitment to the therapeutic process. If no advance notice of cancellation is given, you will be charged my full fee for the missed session.

BILLING AND PAYMENT

Unless otherwise agreed, the hourly fee for psychotherapy is $150.00. You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage which requires another arrangement. If you are covered by insurance, co-payment is expected at each therapy session. What is not reimbursed or covered by your insurance company is your responsibility. Acceptable forms of payment are check, cash, credit card, PayPal or Venmo. Under certain circumstances, fee adjustments or installment plans may be negotiated.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I may use legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action 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/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it may provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. **It is very important that you find out what mental health services your insurance policy covers, i.e., deductible and copay.** If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will provide any information your insurance company requires to determine payment.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will inform you of such requests and provide you with a copy of any report I submit, if you request it.

CONTACTING ME

I make every effort to return calls within 48 hours, with the exception of weekends and holidays, in which case I will return calls on the following business day. ***If you need to contact me, please leave a message at 773-209-2440.*** I am also available by email at alison@alisontoback.com. **Please be aware that cancellations for appointments within 24 hours of your email still follow the cancellation policy.**

In emergencies, call 911 or go to your local emergency room. You can always leave me a message or send me an email and let me know how I can reach you.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

- There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I may be required to file a report with the appropriate state agency.

- If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they give up access to your records. If they agree, I will provide them only with general

information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss. If I suspect you are a victim of physical or sexual abuse, I am required by law to discuss this with the Illinois Department of Child and Family Services (DCFS).

- I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these concerns with you, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Please see following page for a summation of this, an informed consent for treatment, and a signature page where you will be agreeing to the terms listed in this agreement.

Again, I look forward to working with you and am honored to facilitate your process of growth.

This form acknowledges that you have requested professional services from me and have received a copy of the Informed Consent for Services. This letter sets forth the agreement concerning our understanding of such services.

1. You are entitled to receive information from me about my counseling methods, techniques, education and credentials. You have the right to stop talking to me at any time, and/or to seek a second opinion about your concerns.

2. We both understand that it is <u>never</u> permissible for a sexual relationship to develop between a client and a therapist.

3. Our conversations are **confidential.** I will not share anything we discuss with anyone else unless I get your written permission, except in situations outlined in the Informed Consent for Therapy Document you have received.

4. If you participate in whatever services are recommended by me, you agree to pay for these professional services according to the fee schedule you have received. Any payments received from third parties (i.e., insurance) will be credited to your account, however, you are primarily responsible for payment of any outstanding balances.

5. You will be charged for missed appointments cancelled less than 24 hours in advance.

6. Returned Checks: A service charge will be applied for checks returned by your bank for any reason. If two or more checks are returned, I will no longer accept checks from you and you will be asked to pay in cash.

7. Payment plans can be arranged, at your request, if the need for such arrangements can be established. In the event it becomes necessary to use the courts to collect any unpaid balance, you agree to pay reasonable attorney fees and any and all court costs which may be incurred.

I have received the Informed Consent for Services referenced on this page, as well as disclosure of my Health Insurance Portability and Accountability Act protections included in the Notice of Privacy Practices. I agree to read the contract and to bring any questions about its contents or general concerns to my therapist's attention at the following session.

Client Signature _____
Date_____

Parent/Guardian_____
Date_____

(If client is less than 18 years of age)

Witnessed _____
Date_____