Lincoln Square Mindful Therapy, P.C.

4732 N. Lincoln Ave., Suite #10
Chicago, IL 60625

Agreement Regarding Services, Fees, and Client's Rights and Responsibilities

Please Print
CLIENT'S
NAME/S_____

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information you and/or your child(ren) report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this information to the Illinois Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) when you sign a release to have specific information shared, d) if you provide information that informs me that you are in danger of harming yourself or others.
If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client understands he/she is to contact emergency services directly.
Signature(s) _____Date_____

FEES AND INSURANCE: Clients are expected to submit payment at the scheduled session. Fee for a 55-min indv session is $130.00, and $150.00 for a couples/family session; unless a reduced rate has been agreed upon and written here (_____). If insurance is used the fee will be based upon contracted rates between the insurance company and the therapist. If using insurance, the client is responsible for services not covered by the insurance, including, but not limited to, co-payments, co-insurance, and uncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. If the client's insurance company denies payment, the client is responsible for payment. ***Clients who change insurance companies must notify their therapist immediately.*** A change of insurance while in therapy may mean that the client may no longer be covered and therefore responsible for payment. We sincerely appreciate your cooperation. If at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

APPOINTMENT CANCELLATION POLICY: Clients are expected to give their therapist a minimum of 24 hours notice to cancel (or to change) an appointment. **Failure to give 24 hours notice will result in a full fee for the cancelled session**. **Extenuating circumstances are considered when appropriate.**

CONTACTING THERAPIST: Clients may contact their therapist through confidential voicemail or email. During business hours (9:00am to 5:00pm) therapist checks voicemail/email regularly and will make every effort to return telephone calls within 24 hours, unless out of town. In the event of an emergency, clients are should call 911 or go to the nearest emergency room.

Client Signature_____ Date_____
Client Signature_____ Date_____
Therapist Signature_____ Date_____