Life Care Wellness

Professional Services Contract and Informed Consent

Welcome to **Life Care Wellness**. This document contains important information about our professional services and policies. Read it carefully and sign it as an acknowledgement of your agreement to and with these policies.

Professional Services

Life Care Wellness offers integrated professional individual and/or group services:

Psychotherapy	Coaching (life, wellness, executive)	Group Therapy
EMDR	Somatic Experiencing	Addiction Counseling
Divorce & Family Mediation	Medication Therapy Management	Yoga Therapy
Play Therapy	Dance Movement Therapy	Art Therapy

These services involve a collaborative relationship between the therapist and client to identify particular problems and issues to be addressed. There are a number of different approaches and techniques that can be used in this therapeutic process. Some of these approaches can involve touch. Your therapist will explain if touch may be helpful to your treatment and will always ask your permission before touch is used. Alternative forms of treatment are available, such as support groups. Upon request, your therapist will discuss referral options with you.

Such services have risks and benefits. It is risky to reveal oneself to a therapist and the process may evoke uncomfortable feelings. The benefits of such risk may allow one to gain a clearer understanding of the issues and experience an opportunity to adopt new perspectives. The risk of not pursuing treatment may include continued discomfort, deterioration of health and diminished family and social relationships.

Appointments

Sessions are usually scheduled for 53+ minutes, as deemed clinically appropriate. Once an appointment is scheduled, payment upon service is expected, unless a 24 hours advance notice of cancellation is provided (see **Fees** below). We also reserve the right to discontinue services after two missed sessions or for an unpaid bill.

Insurance Reimbursement

Your health insurance policy may provide coverage for mental health services. Life Care's office will facilitate completion and submission of claims to ensure receipt of entitled benefits. ***You, the client, are ultimately responsible for full payment commensurate with the fee regardless of whether or not the insurance company has properly or improperly determined payment.***

Managed Health Care Plans may require advance authorization prior to providing reimbursement. If necessary, our office will assist in obtaining this authorization. ***Ultimately, it is the responsibility of you, the client, to ensure that proper steps are taken to obtain authorization and insurance reimbursement.***

Most insurance agreements require client authorization for the therapist to provide a clinical diagnosis or additional clinical information such as a treatment plan or summary, and, in rare cases, a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential; however, our office has no control over what they do with it.

Contacting your Therapist

A message may be left at the phone number provided by the therapist. In the case of emergency, if you cannot reach your therapist, contact your family physician or go to the nearest emergency room for care.

Fees

Fees for services will be determined prior to service. Payment is expected at the time services are rendered. Please contact the therapist **twenty-four (24) hours** or more prior to the scheduled session should you need to cancel your session. **Life Care reserves the right to bill you for the <u>full</u> fee of this missed scheduled session.** Be aware insurance will not cover this session.

Fees for **Individual Therapy** are $150 for 38-52 minutes or $186 for 53 minutes or more and $186 for **Couples or Family Therapy**. Life Care's standard session is one hour. Acceptable forms of payment are personal check,

cash, credit card or debit card. A $50.00 fee is charged for **NSF checks**. *Unpaid balances after 90 days will incur an interest charge of 1.5 percent per month.* These unpaid balances may be sent to **collections** as a last resort.

Please be aware that any work done on your behalf for **legal purposes** will be charged at the following rates: $200/hr for preparation (including records submission), letter or summary writing, phone calls; $400/hr for depositions or court appearances including travel time; *PLUS reimbursement of the fees paid by the therapist for legal consultation about the case.* These fees are not covered by your health insurance. Attendance by your therapist at a **school or hospital staffing** is $300. This fee is not covered by health insurance.

Confidentiality

The confidentiality of all communications between client and therapist are protected by law, and can only be released to others with your written permission. However, the law outlines certain exceptions to confidentiality:

- A valid court order by a judge.
- For the protection of harm to self.
- For the protection of harm to another including abuse or neglect of a child, elderly or disabled person. Should such a situation occur, the therapist will make every effort to fully discuss with you the implementation of this mandated report.
- In compliance with the Firearm Concealed Carry Act (PA 98-063) and Firearm Owner identification (FOID) Reporting System requirements as part of the Illinois Department of Human Services (IDHS), clinical health professionals are required to report patient information to the Illinois Department of Human Services without any prior consent when someone is determined to be a "clear and present danger" to themselves or others. This disclosure is not discretionary, but is mandated by law.
- To provide the highest level of care, consultation with other mental health professionals is sought periodically regarding cases. During consultations every effort is made to protect client identity.

Statements of Understanding

- I acknowledge that I have received, have read (or have had read to me), and understand this "Professional Services Contract." I further acknowledge that I have had the opportunity to ask questions about the contract with my therapist.
- I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to take an active role in this process.
- I understand that no promises have been made to me as to the results of treatment or procedures provided by this therapist.
- I am aware that I may stop my treatment at any time. The only thing I will be responsible for is paying for the services I have already received. I understand that stopping treatment prematurely will result in continuing to deal with the problem that brought me to therapy, now without assistance, or the development of other issues.
- I know that I must call to cancel an appointment at least 24 hours before the time of the appointment or full payment is expected.
- I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), providers of, and services or treatments I receive. I understand that if payments for the services I receive are not made, the therapist may stop treatment.
- I acknowledge that my signature below also serves as an opt-in permission to include my email address on the Life Care Wellness newsletter, and that I may unsubscribe from the newsletter at any time.

I understand the above information and have asked for clarification regarding information that was unclear to me. I wish to participate in therapy with therapist named below.

Self_____ Client_____ Date_____

Parent _____ Client_____ Date_____

Therapist _____ Date_____