

Sign and return to your therapist.

# SMART LOVE<sup>®</sup>

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## FAMILY SERVICES

### Counseling Program

#### PSYCHOTHERAPIST-CLIENT THERAPY CONTRACT & AGREEMENT

Welcome to Smart Love Family Services. This document contains important information about our professional services and business policies, and a summary about HIPAA. **Please carefully read this entire document.**

#### PSYCHOTHERAPEUTIC SERVICES

Psychotherapy is not easily described in general statements. Our therapists are here to answer any questions you have about the therapy process for you or your child. Psychotherapy has been shown to have many benefits, such as improved relationships, solutions to specific problems, and overall greater well-being. Because psychotherapy involves addressing problems, it can also cause people to experience upset and uncomfortable emotions. There are no guarantees of what you will experience, but our therapists are here to answer your questions and help you understand the process.

#### SESSIONS

Sessions are typically held for 45 to 55 minutes once or twice a week. Your therapist will meet with you for the first few sessions to hear how we can best help you and to make an assessment of your needs and goals. After the therapist shares his/her impressions, you can make a determination of whether you want to continue with therapy at SLFS or if you want help seeking services outside of SLFS.

**For Parents (Please also see handout on child therapy enclosed in packet):** Initially, a therapist will meet with your child for 3 sessions individually to get to know your child. After those sessions, the therapist will schedule a parent feedback session to review impressions and recommendations, as well as to get a better sense of your concerns for your child. If parents want to come in for additional parent feedback sessions, this can be scheduled outside of the child's therapy time so your child is not missing his or her weekly appointment. Parents can also contact the therapist by phone at any time during the treatment process. Therapists are available for brief phone conversations. In the event you have questions that require more time, it is most helpful to schedule an in-person parent meeting. Please note that in-person parent meetings are typically covered by insurance and will be billed accordingly (families will need to pay the applicable co-pay, self-pay or coinsurance for all parent meetings).

#### IN THE EVENT OF A CLINICAL EMERGENCY : CALL 911

**In the event that you have a clinical emergency that needs immediate attention, you need to call 911 or go to your nearest emergency room. After one of those steps, you can leave a message for your therapist on his/her SLFS voicemail to inform him/her of the situation.**

#### CANCELLATION POLICY

Once you are scheduled for a regular therapy appointment, you will be expected to pay for that session each week. SLFS charges \$75 for all missed scheduled appointments.

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The exceptions to being charged are as follows:

- Significant illness or family emergency and you call your therapist to cancel before the appointment time
- Conditions exist, such as severe weather, that make it impossible for you to attend
- Session occurs on a day that SLFS is closed or during a therapist's absence
- You provide your therapist with at least 24 hours notice

It is important to note that if you do not cancel the appointment ahead of time in the above instances, you will be charged as a missed appointment. Insurance companies do not provide reimbursement for cancelled sessions. Therefore, if you miss an appointment that does not fall under one of the exceptions listed above, you will be charged \$75.

### **IMPORTANT INFORMATION ON CANCELLATIONS**

SLFS provides psychotherapy services that occur on a weekly basis at the same time because we find therapy is much more effective when sessions are regular and consistent. Your therapist is holding this time slot for you. As such, it is important that sessions are attended on a regular, consistent basis. Clients are able to cancel up to 4 times every 6 months. Unless there are extenuating circumstances, SLFS will charge for cancelled appointments even if they fall in the cancellation policy if there are more than 4 cancellations in a 6-month period.

### **PROFESSIONAL FEES**

Our full fee for psychotherapy sessions at Smart Love Family Services ranges from \$175 to \$200 depending on the service provided. Your fee may vary depending on whether we are contracted with your insurance plan and have agreed to a different fee schedule.

- **Weekly co-pays or self-pays are due at the time of service, and you will be required to put a credit/debit card ON FILE that will be charged each visit.**
- **IN NETWORK: Coinsurances, deductibles, cancellation fees and other balances are due 15 days from receipt of receiving your statement in the mail from The Billing Company.** These are mailed out at the beginning of each month
- **OUT OF NETWORK PLANS are required to put a credit/debit card on file that will be charged at each session for the agreed upon rate to cover deductible and coinsurance fees.**
- Clients with IN NETWORK HIGH DEDUCTIBLES \$1000 OR HIGHER THAT HAVE NOT BEEN MET are encouraged to put a credit card on file that will be charged each session for \$75 until your deductible is met to avoid incurring a large balance.
- When SLFS receives a bounced check, clients are expected to pay the amount plus \$25.00, the fee incurred by the bank.

### **BILLING YOUR INSURANCE**

SLFS uses TBC Billing Company to do all of our insurance billing. SLFS provides a courtesy to clients to check insurance benefits, but this does not guarantee coverage. Clients are ultimately responsible for paying for all fees incurred even in the event insurance does not cover services. SLFS also reserves the right to bill clients for balances in the event that insurance does not pay in a timely manner. SLFS will bill out-of-network insurance as a courtesy for you. If you have a high deductible plan, you will also be required to keep a credit card on file but can still choose to pay by check. If you have any questions about billing, it is most helpful to contact TBC directly at (773) 665-8052, ext. 246.

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You should also be aware that your contract with your health insurance company requires that you authorize me to provide it with information relevant to the services that I provide to you. If you are seeking reimbursement for services under your health insurance policy, your consent and signature below allows me to provide such information. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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 provide you with a copy of any report I submit, if you request it.

It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above. If you would prefer to self-pay for your sessions and do not want us to inform your health plan that you are receiving psychotherapeutic services, please inform us of this preference.

### **SERVICES NOT COVERED BY INSURANCE THAT REQUIRE SELF-PAY**

Please note that some services, such as 45-minute phone sessions, school observations, attendance at a child's school meeting, or any type of formal report writing (other than formal testing reports) are not covered by your insurance but are available to you for a reduced self-pay rate of \$100 per hour. In addition, if you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of the therapist's professional time at a full self-pay rate of \$175 per hour, including preparation and transportation costs, even if your therapist is called to testify by another party.

### **CONTACTING YOUR THERAPIST**

If you have a general question about our program, you may contact SMART LOVE FAMILY SERVICES' main line at (773) 665-8052, ext. 4. If you need to reach your therapist directly, please call him/her on his/her office extension (press 9 for a staff directory). Calls will be returned within 24 hours during regular business hours. Please note that by signing this agreement, you are giving SLFS and your therapist permission to contact you and leave messages on the phone numbers you provide.

**In the event that you have a clinical emergency that needs immediate attention, you need to call 911 or go to your nearest emergency room. You can leave a message on your therapist's voicemail after you take one of those steps. Your therapist will call you back as soon as possible.**

### **ELECTRONIC COMMUNICATION POLICY (USE OF EMAIL/TEXT)**

Please be advised that emailing and texting are not secure forms of communication, and therefore, we cannot ensure confidentiality of any information sent via email/text. If you choose to contact your therapist by email/text, in order for him/her to respond to you by email/text, you must authorize him/her to do so (see below). Because email/text is not secure, it is best not to email/text detailed or personal information and to use email/text only for brief and logistical issues such as scheduling. Therapists will not conduct therapy through email/text communication (i.e., will not respond to clinical concerns or questions via email/text). Please discuss clinical matters in person or over the phone, including emergencies (never use email/text to communicate emergencies).

### **USE OF SOCIAL MEDIA**

SLFS has a social media policy that does not allow therapists to accept contact requests from clients on any social networking sites. This policy is in place because adding clients as contacts on these sites can

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compromise client confidentiality and privacy, which is very important for us to protect. Please feel free to talk to your therapist about this if you have questions.

### **CONFIDENTIALITY AND LIMITS ON CONFIDENTIALITY**

The law protects the privacy of all communications between a client and a mental health professional. In most situations, your therapist can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois law. However, in the following situations, no authorization is required:

- Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, your therapist will make every effort to avoid revealing the identity of his/her client. The other professionals are also legally bound to keep the information confidential. If the therapist you are working with is receiving professional training in clinical psychology or social work, they may be required to present case material through their clinical program for supervisory and instructional purposes. Again, all identifying information will be disguised and all participants are bound to maintain confidentiality.
- You should be aware that we practice with other mental health professionals at SMART LOVE FAMILY SERVICES, and that we have administrative staff. In most cases, your therapist will need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the agency.
- SMART LOVE FAMILY SERVICES engages in quality improvement and evaluation activities to ensure we are providing effective care to our clients. Clients/Parents of Minor Clients may be asked to provide information about client characteristics and treatment progress through evaluation forms. In a format that preserves your anonymity and confidentiality, we may use this information for external purposes including for research purposes; in reports for presentations to other professionals or to funding sources; and we may seek to publish such information. All information will always be de-identified.
- SMART LOVE FAMILY SERVICES also has a contract with The Billing Company, our billing specialist, who does all of our insurance billing for our clients. As required by HIPAA, we have a formal business associate contract with this business, in which it promises to maintain the confidentiality of this data except as allowed in the contract or otherwise required by law.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-client privilege. Your therapist cannot disclose any information without a court order.
- If a government agency is requesting the information for health oversight activities, the agency may be required to provide it for them.
- If a client files a complaint or lawsuit against the agency or therapist, the agency may disclose relevant information regarding that client in order to defend itself.
- If you file a worker's compensation claim, and your therapist is rendering treatment or services in accordance with the provisions of Illinois Workers' Compensation law, your therapist must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

There are some situations in which your therapist is legally obligated to take actions, which are necessary to attempt to protect others from harm and your therapist may have to reveal some information about a client's treatment.

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- If your therapist has reasonable cause to believe that a child under 18 is known within a professional capacity to be an abused or neglected child, the law requires that the therapist file a report with the local office of the Department of Children and Family Services. Once such a report is filed, the therapist may be required to provide additional information.
- If your therapist has reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that the therapist file a report with the agency designated to receive such reports by the Department of Aging. The therapist may be required to provide additional information.
- If you have made a specific threat or violence against another or if your therapist believes that you present a clear, imminent risk of serious physical harm to another, your therapist may be required disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you.
- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself, your therapist may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.

If such a situation arises, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

## **PROFESSIONAL RECORDS**

The laws and standards of mental health professions require that Protected Health Information about you is kept in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them with your therapist or accept a written treatment summary. If you want a copy of your medical record, you must pick it up in person at the clinic to ensure security of the record. **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. Parents of children between the ages of 12 and 17 cannot examine their child's record unless the child consents and unless the therapist finds that there are no compelling reasons for denying any access. Parents have a right to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, progress updates and services needed. Any other communication will require the child's (ages 12-17) Authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case, the therapist will notify the parents of the concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and, to the best of the therapist's ability, handle any objections the child may have.

Regardless of a child's legal age, we take the confidentiality of a minor's record seriously. Without confidentiality, children have difficulty trusting, which can interfere with treatment progress. Therefore, whenever possible, we encourage parents to accept a brief written therapy progress update (for no charge) or an in-person meeting that can answer the questions they have in place of a copy of the child's record. We believe this meets the needs of the parents and other providers, while also protecting very private information for the child and ensuring that the record is kept safe. Further, treatment progress summaries are often times more helpful to parents because it provides a comprehensive description and overview of the child's treatment progress. In the event that a parent still requests a record, we ask that the parent come in person to the clinic to pick up the record to protect the confidentiality of the record.

## **CLIENT RIGHTS**

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your therapist amend

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your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records. HIPAA requires that we give you a paper copy of this Agreement, the attached Notice form for use and disclosure of PHI for treatment, payment and health care operations, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

**QUESTIONS**

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 what we can do to help. If during your time of receiving services at SLFS, you have any questions about your therapy, billing or anything else, please ask us.

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Please neatly print the client's name above. Thank you.

**Consent to Contact You/Leave Messages Via Phone and/or Email:**

Indicate at which number(s)/email SLFS has permission to contact you or leave you a message:

**Client or Parent of Minor:**

\_\_\_\_\_ (home)                      \_\_\_\_\_ (work)  
\_\_\_\_\_ (cell)                        \_\_\_\_\_ (email)

**Client (Minor)**

\_\_\_\_\_ (home)                      \_\_\_\_\_ (work)  
\_\_\_\_\_ (cell)                        \_\_\_\_\_ (email)

**Emergency Contact Information:**

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Name	Relationship to Client	Phone Number
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**Your signature below indicates that you have read this agreement and agree to its terms, including that you are consenting for SLFS to bill your insurance company (if applicable) and to release PHI as required by your insurance company, that you are making an informed choice to consent to treatment, and also serves as an acknowledgment that you have received the HIPAA Notice Form described above.**

\_\_\_\_\_  
Client Signature (age 12 and older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent and/or Guardian

\_\_\_\_\_  
Date

**\*\*(There is an additional copy of this agreement in the welcome packet for your records)**