FASH COUNSELING

Fash Counseling Agreement & Policies
Informed Consent

Welcome

Welcome to Fash Counseling. This document contains important information about our professional services and business policies. Today's appointment will take approximately 50-60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights.

Fash Counseling will provide counseling services to individuals regardless of race, color, creed, handicap, socioeconomic status and/or sexual orientation.

Client Policies and General Information

Psychotherapy Services:

All therapists at Fash Counseling have earned a Masters Degree or higher in the counseling profession. All therapist are licensed by the state of Illinois as an LPC, LSW, LCPC, LCSW, Psy.D. or PhD. Lastly, all of our therapists have many years of clinical experience treating children, adolescents, adults, families, couples and groups.

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. Jenna Fash practices a standard eclectic therapeutic approach that can be utilized for the problems you hope to address. Psychotherapy has both benefits and risks. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. Risks sometimes include experiencing uncomfortable feelings, as psychotherapy requires discussing unpleasant aspects of your life. Benefits include the opportunity to be listened to and understand in a nonjudgmental manner. In order to be most successful, you should work on things you talk about with your therapist during scheduled sessions at home. There are no guarantees about what counseling will do for you.

Appointments:

Sessions are 50-60 minutes. Once an appointment is scheduled, payment is expected unless you provide 24 hours advance notice of cancellation. Missed appointments or appointments not canceled within 24 hours will be charged to your designated credit card.

Confidentiality and Emergency Situations:

Fash Counseling complies with those standards set forth by HIPAA. The information you provide your therapist will be treated as strictly confidential. What you tell us, stays with us. However there are exceptions, including those situations which we are required by law to report such as, suspected abuse to an individual (child and/or adult); harm or threat to self or others. While these situations are rare, you should be aware of

the possible occurrence as well as the protective actions required by your therapist. These actions may include, notifying the potential victim, notifying the police, seeking appropriate hospitalization for the client, and/or contacting family members or others who can help provide protection.

Your therapist may occasionally find it helpful to consult about a case with another professional (consultant). In these consultations, he/she will make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations.

If an emergency situation for which the client or guardian, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Your therapist will follow those emergency services with standard counseling and support for the client or the client's family.

Financial & Insurance Policies

As a courtesy Fash Counseling will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay, coinsurance or fee due. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your insurance or coverage changes, you are responsible for informing Fash Counseling of this change.

If your balance exceeds $200.00 we will need to ask that you pay for your services when rendered. In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

We ask that every client authorize payment of benefits directly to Fash Counseling.

Court Cases

Therapists of Fash Counseling do not become involved in any custody, visitation, or legal disputes.

Credit Card Authorization

Fash Counseling reserves the right to charge the client's designated credit card for session fee, co-pays, coinsurance, and/or deductibles at the time services are rendered. Accounts not paid within 30 days of the statement date are charged the full amount due.

Diagnosis as Requirement for Insurance Billing

You should be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis. This information will become part of the insurance company's record. All insurance companies claim to keep such information confidential. Fash Counseling is not responsible for your information once it is in the hands of the insurance company. You have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage.

Dissolution of Marriage & Payment

We expect the parents to work out payment arrangements between themselves as well as with Fash Counseling at the start of treatment. Also, we will ask you to provide a copy of the divorce decree. .

Fees & Payment Expectations

Fees for psychotherapy are expected to be paid at the time services are rendered. Fash Counseling can send statements upon request. We accept cash, check and credit cards. There is a $25.00 service charge for personal checks returned for any reason. You are expected to provide payment based on the estimated payment information we received from your insurance company. This information is only an estimation of benefits and subject to change.

Any pay arrangements, other than payment in full must be approved in order to keep your account from being considered past due.

Records/Report Requests

Preparation of any report as requested by the client or another party representing the client is subject to our standard fee. Reasonable efforts are made to provide only the minimal information required. A records request by the client or another party representing the client is subject to a 0.25/page charge.

Missed and Late Cancelled Appointments

If you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate of $145 for Masters Level Clinicians and $160 for Doctorate Level Clinicians. These charges are billed to the designated credit card.

We sincerely appreciate your cooperation and at any time you have questions regarding insurance, fees, balances or payments please feel free to ask.

Telephone Calls/Telehealth Sessions

Unscheduled telephone calls between the client and therapist that exceed ten minutes will be billed at the rate of $45.00 per 15 minute increment. Scheduled telephone or Telehealth sessions are billed at Fash Counseling's normal rates. Insurance does not pay for telephone or Telehealth sessions.

You may have a copy of this form if requested.

Statements of Understanding

(1) I acknowledge that I have received, have read (or have had read to me), and understand the Counseling Agreement and Policies. I further acknowledge that I have had the opportunity to ask questions about the agreement with my therapist.

_____ (initials)

(2) I do hereby seek and consent to take part in the treatment by Fash Counseling. I understand that developing a treatment plan with a 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 of any procedures provided by my therapist.

_____ (initials)

(3) I am aware that I may terminate my treatment at any time and that I am still responsible for paying the services already rendered. I understand that the financial, including insurance aspect, of the counseling process is my complete responsibility.

_____ (initials)

(4) I understand that phone and Telehealth sessions have therapeutic limitations. I acknowledge that my therapist takes precaution to ensure confidentiality, but understand he/she cannot guarantee it using these devices.

_____ (initials)

(5) I understand that I must call to cancel an appointment at least 24 hours before the time of my appointment or full payment is expected. I understand that Fash Counseling has the right to charge my designated credit card.

_____ (initials)

(6) I understand that if I do not pay my bill within 30 days of the statement date or make financial arrangements, Fash Counseling has the right to charge my designated credit card the full amount. I further understand that if I have not made a payment on my account within 60 days, Fash Counseling has the right to turn my account over to collections.

_____ (initials)

(7) 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), and providers of any services or treatments I receive. I understand that if payment for the services I receive is not made, then I will discuss a payment plan with my therapist.

_____ (initials)

(8) I acknowledge that, according to HIPAA regulations, I have been offered Fash Counseling's Notice Form of Privacy Policy.

_____ (initials)

Client Signature: _____ Date: _____
(12 years and older)

Parent/Guardian Signature: _____ Date: _____

I, the therapist, have discussed the information above with the client (and/or with his/her parent, guardian or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Therapist Signature _____ Date:_____