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Statement of Understanding & Financial Obligation

These guidelines have been written to inform you, the client, about the basic terms, conditions and professional practices that promote a successful therapeutic experience. Please read this information carefully and acknowledge your understanding by signing below.

Appointments

Optimal results occur when you consistently schedule appointments and maintain regular attendance. Each session lasts 45-55 minutes. All appointments need to be scheduled in advance. ***Appointments canceled or rescheduled with less than 48 hours notice will be charged a cancellation fee of $75*.*** Payment will be your responsibility since insurance companies do not pay for failed appointments. In cases of emergency or special circumstances where a 48 hour notice is not possible, the late cancellation fee may be waived. ****Please note cancellation fees will be charged to the credit card on file the day of the missed/canceled appointment.***

Payment for Services

Our fee for an initial 45-55-minute individual session is $175; subsequent 45-55-minute sessions are $150. If you are a member of an insurance plan for which we are a provider, your rates may be different. If you choose to utilize your insurance benefits toward payment of your session, we will request pre-certification for treatment as needed, complete the necessary paperwork, and submit invoices to your insurance company in a timely manner. You will be responsible for treatment not covered by your insurance. ***Payment for services not covered by insurance is due at each session.*** There are some special circumstances in which we may agree to provide services at a sliding/discounted fee.

Confidentiality

All information you share in therapy including case notes and records are confidential and will not be shared with anyone without your written consent or that of a legally authorized person (i.e. parent or guardian). However, this policy does not apply in the following situations:

1. If you use your insurance or Employee Assistance Program (EAP) benefits, information about your treatment will be shared with them.
2. As part of professional development, therapists regularly seek clinical consultation and may discuss information about your case with another professional psychotherapist who maintains the same policy of confidentiality indicated above.
3. If it is determined that you may be a danger to yourself or somebody else, of any suspected abuse or neglect of a child/elder/dependent adult, of a situation involving stalking, or of a threat to national security, all therapists are required by law to report this information to a designated agency.
4. Under state and federal law, there may be other exigent circumstances that would require disclosure.
5. In the event that seeking collections become necessary, certain basic information may be disclosed to obtain payment for services provided under this agreement.

Contact Information

Between appointments, please feel free to contact your therapist or leave a message by telephone. For billing inquiries please contact Farah Hussain Baig at 312-523-9959. If you are experiencing an urgent situation or are canceling an appointment for that day, please call and leave a message if your therapist is not immediately available. Your therapist will do their best to return messages in a timely manner. ***In the case of an emergency, if your call is not returned in a timely fashion proceed to the nearest emergency room or dial 911.***

Informed Consent

I have read and understand all of the terms and conditions stated above. All my questions have been answered fully.
I understand and agree to the terms and conditions of this agreement.

______________________________	__________	______________________________	__________
Signature of Patient	Date	Witness	Date
______________________________	__________		
Signature of Parent or Guardian	Date		

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