1095 Pingree Road, Suite 202
Crystal Lake, IL 60014

Informed Consent for Treatment and/or Services

Client's Name: _____ Date: _____

Confidentiality: You have the right to have the issues you discuss with your therapist kept strictly confidential. The information you reveal will be kept private and will not be revealed, in most situations, to any other person or organization without your written permission. The following are examples when the disclosure of confidential information is necessary and/or required by law:

1) When there is imminent threat of harm to self;
2) When there is credible threat of physical harm to a third party;
3) In the case of abuse or neglect of children or vulnerable adults;
4) When court ordered by a judge (not merely a subpoena);
5) As needed by your insurance company for billing or quality management purposes.

Contacting the Therapist: The therapist is often not immediately available by telephone. In the event, you need immediate assistance, please call 911 or go to the nearest emergency room. For non-emergency communication, you can leave a message on your therapist's voicemail, which is checked regularly. Every effort will be made to return your phone call within 2 hours, except for weekends and holidays.

Billing and Payment: You will be expected to pay for services at the time of each appointment, including any co-payments required by your insurance. Once an appointment hour is scheduled, you must provide 24 hours' advance notice of cancellation. If possible, we will try to reschedule the appointment for that week. If you do not contact your therapist within 24 hours to cancel an appointment, you will be charged a $50.00 no show fee. **If you are late for a session, that lost time may be included in the 50-60 minutes per session. Please make every effort to be on time.**

Responsibility of Payment:

Private Pay - $130.00 per hour session (50-60 minutes) payable on the date of service.

Insurance: Co-Payment or client portion of appointment payable on the date of service.

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Cancellation and Failed Appointments: I understand that my therapist reserves an appointment time for me. I agree to notify my therapist twenty-four (24) hours prior to my scheduled appointment iin the event I must cancel for any reason. Changes in employment or school responsibilities may be an exception as agreed upon by the therapist. I understand that there will be a $50.00 charge for 'no-show' or late cancellations.

If your account balance has not been paid for more than 60 days, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a client's treatment is his/her name, the nature of the service provided, and then amount due.

I have been informed of my rights about privacy. I accept, understand, and agree to abide by the contents and terms of this agreement. I hereby grant permission to **Lakeview Counseling Services** to provide routine evaluation and treatment services as may be deemed necessary or advised for the diagnosis and/or services. I understand that **Lakeview Counseling Services** will work with me in the office in assessing the client's needs, developing goals and resolving problems.

_____ _____

Client's Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness/Therapist Signature Date