Lakefront Counseling Group, Ltd.
155 N Michigan Ave, Suites 325-326
Chicago, IL 60601
p: 847-942-2006
fax: 312-239-6000
www.lakefrontcounselinggroup.com

OUTPATIENT SERVICES CONTRACT

Welcome to Lakefront Counseling Group, Ltd. We hope that this form will answer some of your questions as you seek therapy. Please let us know if you have any questions that are not addressed here. When you sign this document, you are stating that you understand and will adhere to the information in this Outpatient Services Contract.

PSYCHOTHERAPY SERVICES

We provide psychotherapy services for children, adolescents, adults, couples and families. The first appointment(s) serves as an intake appointment. We will want to hear about the difficulties that led to you making an appointment, goals for therapy, and general information about yourself and your current life situation. By the end of this first appointment, we will give you some initial recommendations on what we think will help.

If you and your therapist decide to work together in therapy, you will collaborate on a treatment plan that incorporates effective strategies to help with whatever difficulties you are hoping to reduce in therapy. Sometimes more than one approach is helpful. Individual, couples and family therapy sessions usually last 45-53 minutes (depending on your needs and/or insurance benefits) unless otherwise arranged. Oftentimes, sessions are set for once or more each week, but this varies based on what seems most appropriate for your particular situation.

Therapy can be extremely helpful, fulfilling and impact your life in positive ways. It requires active involvement, honesty, and openness in order to change thoughts, emotional reactions and/or behaviors. We encourage you to discuss any concerns you have about our work together directly so that we can address it in a timely manner.

AVAILABILITY BETWEEN SESSIONS

If needed, you can leave your therapist a message on our 24-hour voicemail box at (847)942-2006. When you leave a message, include your telephone number and best times to reach you. We make every effort to return calls in a timely manner. In the rare occurrence that a message is missed or accidentally deleted, if you do not hear back from us within one day, please leave a second message. If we are unavailable for an extended time, such as on vacation, we will inform you of the contact information for the therapist on-call.

If you are in an emergency situation and cannot wait for us to return your call, go to the nearest emergency room or call 911. Lakefront Counseling Group, Ltd. is not a crisis facility. Do not contact us by email or fax in an emergency, as we may not get the information quickly.

RATES, INSURANCE and PAYMENT

If you have health insurance and decide to use it, it is important for you to verify your mental health benefits so you understand your coverage prior to your appointment. Please obtain information regarding your deductible, co-payment, annual limits, maximum paid per session,

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number of approved sessions, and information on any other restrictions/limitations. Some insurance companies require a pre-certification before the first appointment or they will not cover the cost of services.

Fees:

* Individual, Couple, and Family Therapy: $250 for the initial session of 1 hour. $200 for all 52 minutes session, $165 for 45-minute session. This includes telephone and online therapy sessions. *Some health insurance carriers cover Telehealth (telephone/online therapy).*
* Professional services including: report preparation, letters on your behalf and treatment summaries will be billed at a $200 (prorated at $3.33/minute).
* There is a charge for professional services that are rendered over the phone. Telephone calls will be billed at a $200 rate (prorated per minute) for calls over 15 mins unless otherwise agreed upon.
* Professional services outside the office: Services provided outside the office, including attendance at meetings with other professionals you have authorized, meeting with clients while hospitalized, school meetings, IEP, and staffing will be billed at $200that is, for time Lakefront Counseling Group therapists are out of the office on my behalf.
*These fees are reviewed annually on Jan 1st and increase by $5 for each visit.

Payment:

* I understand that I am expected to pay for each session at the time it is held. This applies to self-pay (not using insurance) clients as well as those who have co-payments. Acceptable forms of payment include cash, check and major credit cards. Authorization of treatment from your insurance company does not necessarily mean that they will pay for the treatment you receive. Occasionally, insurance companies may deny a claim. If this were to occur, it is your responsibility to pay Lakefront Counseling Group, for claims denied and to investigate this with your insurance company.

Appointments and Cancelation Policy:

***** I understand that once I schedule an appointment I am expected to pay for it unless I cancel the appointment within 1 business day in advance. **IF I CANCEL AN APPOINTMENT WITH LESS THAN 24 HOURS NOTICE or miss an appointment, I WILL BE CHARGED the full cost of the session.**

Please note that insurance companies do not reimburse for missed appointments.

SOCIAL MEDIA POLICY

In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites.

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We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly.

Text messages and emails are only to be used for scheduling, changing or canceling appointments.

Telehealth

If we agree, I will consider conducting appointments via jituzu a HIPPA compliant website when you are unable to meet with me in person. The hourly fee for the appointment is the same as our usual appointment charge. Note that some insurances pay for telehealth services and some do not.

PROFESSIONAL RECORDS

Both law and the standards of our profession require that we keep appropriate treatment records. If we receive a request for information about you, you must authorize in writing that you agree that the requested information released.

CONFIDENTIALITY

In general, law protects the confidentiality of all communications between a client and a mental health clinician, and we can only release information to others with your written permission. However, there are a number of exceptions, which are have indicated below. More information is provided about this in your HIPAA statement.

In judicial proceedings, if a judge orders the records released, we have to release the records. In addition, we are ethically and legally required to take action to protect others from harm even if taking this action means we reveal information about you. For example, if we believe a child, elderly person or disabled person is being abused or neglected, we are mandated to report this to the appropriate state agency. If we believe a client is threatening serious harm to another person or property, we must take protective action (through notifying the potential victim, the police, and/or facilitating hospitalization of my client). If we believe a client is a serious threat to harming him/ herself, we must take protective action (arranging hospitalization, contacting family/ significant others for notification, and/ or contacting the police). We would make reasonable effort to discuss any need to disclose confidential information about you, and we are happy to answer any questions you have about the exceptions to confidentiality.

MINORS

If you are under 12 years of age, please be aware that the law may provide your parents the right to examine your treatment records. If you are between the ages of 12 and 18, the law may

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provide your parents the right to examine your treatment records if after being informed of your parents' request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying the access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discuss.

COURT RELATED SERVICES

We will not serve as a witness for you in any type of litigation including child custody evaluations, personal injury matters, employment, or workers compensation related matters. By signing this agreement, you acknowledge that we will not be involved in such proceedings and if we are serviced with a subpoena to testify, you will bear the legal fees of having the subpoena squashed.

COMPLAINTS

If you have a concern or complaint about your treatment or about your billing statement, please talk to us about it. We will take your criticism seriously, openly, and respond respectfully.

QUESTIONS

If during the course of your therapy, you have any questions about the nature of your therapy or about your billing statement, please ask.

A FINAL WORD

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 with us what we can do to help.

Our Responsibilities:

Lakefront Counseling Group, LTD, is required by law to maintain the privacy and security of your protected health information. We will not use or disclose your health information other than as described here unless you provide written authorization. You may revoke your authorization at any time, in writing, but only as to future uses or disclosures and only where we have not already acted in reliance on your authorization.

(For additional information:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

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We are required by law to provide you with this *Notice of Privacy Practices*. This *Notice* describes how we use your health information and disclose it with others. We must abide by the terms of this Notice currently in effect. We reserve the right to change the terms of our *Notice* and to make the new *Notice* provisions effective for all health information that it maintains. We will review this policy with all existing patients and all new patients.

Uses and Disclosures:

The following are the types of uses and disclosures of your protected health

information that we are legally permitted to make:

A. Treatment:

We may use and disclose your protected health information to provide treatment, to coordinate care, or to manage your healthcare and other related service by sharing it with other professionals, including covering physicians. *Example: We discuss your medication treatment with your primary care physician*.

B. Payment:
We can use and share your health information, as needed, to bill and obtain payment for my health care services from health plans or other entities. *Example: We give information to your health insurance plan for prior authorization of a medication*.

C. Healthcare Operations: We may use or disclose your health information in order to conduct the business of providing healthcare, to improve your care, and to contact you when necessary. *Example: quality assessment and improvement activities.*

D. Business Associates:
We may disclose your health information to third-part business associates that perform activities or services on our behalf. *Example: We may use or disclose your health information to a business associate that we use to provide reminders to you of upcoming appointments.*

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Notice of Privacy Practices

Other Permitted Uses and Disclosures:

In addition to the above permitted uses and disclosures, the following are circumstances in which we are either allowed or required to disclose your health information without your authorization, consent, or opportunity to object (For additional information: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html):

1. Required by Law:
   We may share information about you to the extent that it is required by local, state, or federal laws under the circumstances provided by such law. This includes with the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.
2. Health Oversight Activities:
   We may use or disclose your health information to state agencies and federal government authorities, or to a health oversight agency, for activities authorized by law such as audits, administration or criminal investigations, inspections, licensure, accreditation or disciplinary action and monitoring compliance with the law, including in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. The Illinois Mental Health and Developmental Disabilities Confidentiality Act allows for the uncontested disclosure of your health information to a health information exchange, which oversees the electronic exchange of health information.
3. Public Health and Safety:
   We may disclose your health information for public health activities, including: to prevent or report communicable diseases; to report births and deaths; to report reactions to medications or problems with products; to notify a person who may have been exposed to a communicable disease, or may be at risk for contracting or spreading the disease.
4. Research:
   We may use or disclose health information for research that is approved by an Institutional Review Board when written permission is not required by federal or state law. This may include preparing for research or informing you about research studies in which you might be interested.
5. Serious Threat to Health or Safety:

We may be required to use and disclose your health information to prevent or lessen a serious threat to a person's or the public's health or safety. If you present a clear and present danger to yourself and refuse to accept the further appropriate treatment, and we have a reasonable basis that you can be committed to a hospital, then we must seek said commitment and may contact members of your family or other individuals if it would assist in protecting you. If you communicate to us an explicit threat to kill or inflict serious bodily injury upon an identified person or persons, and you have the apparent intent and ability to carry out the threat, then we must take reasonable precautions. Reasonable precautions may include warning the potential victim, notifying law enforcement, or arranging for your hospitalization. We must also do so if we know you have a history of physical violence and we believe there is a clear and present danger that you will attempt to kill or inflict bodily injury on this person or persons.

6. Legal Proceedings:
   We may be required to disclose health information in the course of any judicial or administrative proceeding in response to a legal order or other lawful process, including a subpoena, to the extent that such disclosure is authorized and permissible under the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

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7. Law Enforcement:
   We may be required to disclose health information for law enforcement purposes.
8. Worker's Compensation:
   We may use and disclose your health information as required to comply with worker's compensation laws and other programs that provide benefits for work-related injuries or illnesses.
9. Coroners, Funeral Directors, and Organ Donation:
   We may be required to disclose health information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also disclose health information to a funeral director or their designee, as necessary to carry out their duties. Your health information may also be disclosed to organizations that facilitate organ, eye, or tissue donation or transplantation.

Your Individual Rights:

Although your medical record at our office is our property, your health information that it contains belongs to you. The following is a statement of your rights with respect to your health information, including a brief description of how you may exercise these rights:

1. You have the right to inspect and to request a copy of your medical record.
   At any time, you may inspect and obtain a copy of health information about you, including your medical and billing record, which may be used to make decisions about your care. All requests to access your record must be made in writing to Lakefront Counseling Group, Ltd and will be processed within 30 days. If you request a copy of your records, we may charge you a reasonable, cost-based fee. 1You have the right to request an amendment to your medical record.
2. You may request that we amend your treatment and billing information if you believe the information is incorrect or incomplete, for as long as we maintain the information. If for some reason we deny your request, we will give you a written statement within 60 days with the reasons for the denial, as well as what other steps are available to you.
3. You have the right to request confidential communications.
   You can ask us to contact you in a specific way (e.g., by cell phone or home phone) or to send mail to a different address. We will make every effort to accommodate requests, provided you supply a valid alternative address or other method of contact. In certain cases, we may need to contact you and may do so at the original address or phone number if attempts to contact you at the alternative locations are not successful.
4. You have the right to request a restriction on certain uses and disclosures.
   You can ask us to not use or share certain health information for treatment, payment, or practice operations. We are not required to agree to your requested restriction.
5. You have the right to obtain an accounting of disclosures of your health information.
   This right applies to disclosures for purposes other than treatment, payment, of healthcare operations as described above in this Notice. It does not apply to disclosures we may have made to you, that are authorized by you, information provided to family members or friends about your care, or for notification purposes.
6. You have the right to obtain a paper copy of this notice.
   If you would like a paper copy at any time, please ask and we will provide you with a copy promptly.
7. You have the right to file a complaint.
8. If you believe that Lakefront Counseling Group, LTD, has violated your privacy rights, please communicate to us your concerns by contacting Dr. Robyne Howard at the office location. You may also send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights at 200 Independence Avenue, S.W., Room 509F, Washington, D.C., 20201. You may also call this office at 847-942-2006. For further information: http://www.hhs.gov/ocr/privacy/hipaa/complaints/

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You may contact Lakefront Counseling Group, LTD, for further information about the complaint process or privacy practices:

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Phone: 847-942-2006 Fax: 312-239-6000

Notice of Privacy Practices

(Effective as of 7/1/2017)

Notice of Privacy Practices Acknowledgement I understand that, Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read, and understood your *Notice of Privacy Practices*, containing a more complete description of the uses and disclosures of my health information. I understand that Lakefront Counseling Group, LTD, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Lakefront Counseling Group, LTD, at any time to obtain a current copy of the *Notice of Privacy Practices*.

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Client Name: _____

Client Signature: _____ Date: _____

Guardian Signaturee (if minor): _____ Date: _____

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Lakefront Counseling Center, Ltd.
REGISTRATION FORM

(Please Print)

Today's date:				Account #		
Client INFORMATION						
Primary Client's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) S / Mar /Partner/Div /Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Guarantor? Yes No IF No, who will be responsible for bills?	(Former name):	Birth date: / /	Age:	Gender: o M o F o Transgender o Other_____	
Street address:		.:		phone no.: ( )		
Email:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by:		❑ Google Search		❑ Insurance Plan	❑ Psychology Today	
❑ Family	❑ Friend	❑ Website: ❑ Facebook	❑ Can we mail or email you our newsletter?	Can we Text or email you for appointment reminders and invoices? ❑ yes ❑ no		

Client's last name (if part of Couple): First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) S / Mar /Partner/Div /Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	Relationship to Client:	Email address:		Birth date: / /	Age:	Gender:
Street address (if different):		:		phone no.: ( )		

For Child Therapy

Client's last name: First: Middle:					School:	
Is this your legal name? ❑ Yes ❑ No	Relationship to Client:			Birth date: / /	Age:	Gender:

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Street address (if different):	Social Security no.:	phone no.: ( )

Client's last name (if family therapy):	First:	Middle:			School:		
Is this your legal name? ❑ Yes ❑ No	Relationship to Client:			Birth date: / /	Age:	Gender:	
Street address (if different):		Social Security no.:		phone no.: ( )			

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Are you taking any medication? Please List:			Doctor Name:
Have you been in therapy before? ❑ Yes ❑ No	Name of Prior Therapist:	Previous Hospitalizations:	

Insurance Information

Subscriber's last name:	First:	Middle:			ID#		
Group ID:	Relationship to Client:	Are all clients listed above covered by this policy? Yes No		Birth date: / /	Age:	Gender:	
Street address (if different):		:		phone no.: ( )			

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Confidentiality Release Form

I, (patient) _____, (Date of Birth:_____), hereby authorize Lakefront Counseling Group, LTD, to exchange information limited to my medical/psychiatric history, diagnosis, symptomatology, treatment plan, medication, expected duration of treatment and medical/psychiatric alerts directly related to my safety and well-being, including such information related to treatment for alcohol or drug abuse and mental health issues, with my:

Primary care physician: _____

Psychotherapist/mental health counselor: _____

Psychiatrist: _____

Health Insurance Company: -_____

This authorization is valid until one year after the last day of mental health, alcohol, or drug abuse treatment. This authorization is for the purpose of furthering, coordinating, and optimizing my treatment, care, and follow-up. I understand that in an emergency situation, my providers may exchange information about me to the extent allowed by law.

Print Name: _____
Signature: _____
Date: _____

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CREDIT CARD ON FILE

Payments are due at the time of service. Lakefront Counseling Group requires credit card information in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket expenses that accrue each month. You may opt to pay these costs at each session or we can charge those payments once per month, at the beginning of the month. All credit cards will be charged at the beginning of each month when patient statements are mailed out. Please be aware that we will not notify you of credit card being charged ahead of time, but you will receive a paid statement as a receipt by email if your credit card is charged. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroyed.

Please sign below:

Client name: _____

Card Holder Name: _____

Credit Card Number: _____

Expiration Date: _____ Billing Zip Code of Credit Card: _____

Security Code (3 digits on back of card, 4 digits on front if AmEx): _____

Card Holder's Signature: _____ Date: _____

I understand that by signing above, I am authorizing Lakefront Counseling Group, LTD to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, so show or late cancel fees. I understand that Lakefront Counseling Group, LTD will email me a printed statement as proof of payment.