ALONG THE PATH COUNSELING SERVICES, P.C.

PATIENT AGREEMENT

Thank you for choosing Along The Path Counseling Services, P.C. Today's appointment will take approximately one hour. 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. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Along The Path Counseling Services, P.C. employs only clinicians that have earned at least a Masters Degree in their field and are licensed in the State of Illinois. All of our clinicians have significant experience working in mental health and have demonstrated that experience through outstanding clinical successes. Along The Path Counseling Services, P.C. treats adults, adolescents, children, and families and from time to time offers group mental health treatment for specific wellness needs. All of our clinicians practice standard cognitive-behavioral therapy for most conditions, although other healing modalities are used depending on the person or condition. Your assigned clinician's treatment practices, philosophy, and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, our clinicians are obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared d) if you provide information that informs us that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and/or when required by law. If an emergency situation for which the patient or their guardian feels immediate attention is necessary, the patient or guardian understands that they are to contact the emergency services in the community (911) for those services. Along The Path Counseling Services, P.C.'s clinicians will follow those emergency services with standard counseling and support to the patient or the patient's family. A clinician in our practice may also be receiving direct clinical supervision, which is a normal part of counselor training and continuing education. If they are receiving supervision, they will be sharing your protected health information with their clinical supervisor. The supervising clinician is likewise required to maintain your confidentiality as explained above. If your clinician is receiving supervision, they must inform you of this as well as give you their supervisor's contact information. Also, from time to time your counselor may consult with a fellow clinician regarding your treatment. Such consultation usually does not require disclosure of a patient's personal information. If your clinician must disclose personal information in order to effectively consult, they will obtain expressed written permission from you to do so first, in a Consent for Release of Information.*

Signature(s): _____ **Date:** _____
(if patient is a minor, parent or legal guardian sign)

FINANCIAL POLICY

Contracted Insurance Plans: *Along The Path Counseling Services, P.C. is a contracted preferred provider on several insurance plans. While we do our best to keep you informed, it is your responsibility to determine if we are contracted with **your** insurance company. Due to the many different insurance products and changes that often occur with each policy, we cannot guarantee your eligibility and coverage. If we are an in-network provider, we will bill your insurance directly. **All co-pays are due at the time of service**. Any additional financial portion that is the "member's responsibility" such as a deductible or a non-covered percentage may be collected at the time of service. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company denies payment or does not pay the practice within a reasonable period of time (90 days), you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you or issue a credit to your account.* ***Initials:_____***

Non-Contracted Insurance Plans: *If we are not contracted with your insurance company (out-of-network), you will be asked to pay in full at the time of service. We will bill your insurance and credit your account any payment received. Along The Path Counseling Services, P.C. will not accept responsibility for collecting out-of-network insurance claims.* ***Initials:_____***

Divorce Decree: *We are not party to any divorce decrees. The responsibility for payment and the presentation of active insurance cards at the time of service is the responsibility of the accompanying adult.* ***Initials:_____***

Payments: *We accept cash, personal checks, Visa, Master Card, Discover and money orders. Any outstanding balances are due upon receipt of the statement. It is your responsibility to contact us in a timely fashion with questions regarding your account. Any outstanding balance may incur a $10 monthly statement processing fee in addition to the initial balance. All balances reaching 180 days past due may be sent to our collection agency. Should your account be sent to our collection agency and/or attorney to obtain judgment or otherwise satisfy payment of this account, all collection costs, attorney fees, filing fees, interest, and court costs will be added to the total amount due. Failure to pay balances may result in discharge from the practice.* ***Initials:_____***

Social Security Number: *We are granting you credit by rendering services to you before you, or your insurance company, pays us for those services. Any merchant that grants you credit will require your social security number. If you choose to withhold your social security number from your medical record, then all fees will be due at the time of service.* ***Initials:_____***

Returned Checks: *If a check that you provide to us for our services is returned by our bank, your account will be charged a $25 returned check fee, in addition to the original amount of the check. We reserve the right to require payment by cash, credit/debit card, or money order for all future visits.* ***Initials:_____***

Missed Appointments: *If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed a $50 fee. This fee is not payable by your insurance company and will be your responsibility to pay at or before your next appointment. A history of multiple missed appointments may result in limited access to your clinician's schedule or discharge from the practice.* ***Initials:_____***

Release of Medical Records: *Copying, printing, mailing and/or faxing medical records require staff time. The fee for medical records is $25. You must sign a release of medical records prior to the release of your records.* ***Initials:_____***

I have read, fully understand, and agree to the financial policies of Along The Path Counseling Services P.C., and agree to the terms. I also understand that the terms of these financial policies may be amended by the practice at any time without prior notification.

Signature(s): _____ **Date:**_____
(if patient is a minor, parent or legal guardian sign)

NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS: *I/We have read and received a copy of the Notice of Privacy Practices and Patient Rights document.*

Signature(s): _____ **Date:**_____
(if patient is a minor, parent or legal guardian sign)

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that _____ *maybe treated as a patient at Along*
(name of minor)
the Path Counseling Services, P.C. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Parent/Guardian Signature(s): _____ **Date:**_____

Parent/Guardian Address: _____

Parent/Guardian's Social Security Number: _____