



CENTER for GROWTH and LEARNING

REGISTRATION AND RELEASE FORMS INDIVIDUAL AND FAMILY THERAPY

Participant's Name: _____

Participant's Date of Birth: _____

Gender: Male or Female (Circle One)

Parent or Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mom's Cell: _____ Dad's Cell: _____

Emergency Contact: _____ Relationship: _____

Emergency Phone : _____

Email: _____

School and Grade Attending:

Please share your referral source: (Circle One): Long Grove Psych Associates - Familiar with an instructor - Media Social Site - Search Engine - Word of Mouth - Radio Advertisement - Other:

I WILL BE USING (CIRCLE ONE) INSURANCE, CASH OR CREDIT CARD FOR MY PAYMENT.

The Tree House Center for Growth and Learning

FINANCIAL POLICY

Welcome to the Tree House Center for Growth and Learning! We will be pleased to discuss our professional fees with you at any time, however, your clear understanding of our Financial Policy is important at the outset of our professional relationship, in order to minimize any later misunderstandings. Please ask if you have any questions about our fees or policy. We accept cash, checks, FASA cards and Visa/MasterCard/Discover/AmericanExpress.

In-Network Provider:

We are in network providers for Blue Cross Blue Shield and Aetna insurance companies. We participate directly with these health plans. We will submit claims to your carrier for reimbursement. Co-pays and Deductibles must be paid at the time of service. Our policy is to have your credit card on file to be charged at the time of service. Otherwise, we can accept checks or cash on a weekly basis.

Please request your weekly amount that will be due. We will estimate this amount although it may change once your insurance is processed. Please contact us for more information regarding your specific insurance plan.

Initial:_____

Out-of-Network Insurance:

(All insurance plans except Blue Cross Blue Shield and Aetna)

For insurance plans that are not BCBS or Aetna, we are currently an out-of-network provider, which means that we do not participate directly with your health plan. Full payment for the session must be paid at the time of service unless we have come to a private agreement. Most Traditional, PPO, and POS plans have optional "out-of-network" benefits that provide coverage for psychological sessions. Unless you have an HMO, you will likely be covered for a significant portion of our services after your out of network deductible rate has been paid. Receipts will be available after attendance for your submission to your insurance company. Please contact your insurance company for a more detailed explanation of your benefits.

Initial_____

Missed Appointments:

We will typically begin therapy by scheduling one session per week. **Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of the cancellation** (unless we both agree you were unable to attend due to circumstances beyond your control). Insurance companies do not provide reimbursement for cancelled appointments. If you or your child has a fever, is contagious or is vomiting or otherwise sick to his or her stomach, please DO cancel your appointment as you will not be charged for severe illnesses such as the above.

Initial:_____

Billing:

As per our policies, prior to the session, we will request credit card information be kept on file. We are unable to treat a client if we do not have a card on file. We keep your credit card on file for a few reasons. We will charge your co-pay, deductible or missed session fee at the time of your session. In the case you have outstanding debt, after 45 days of non-payment we will charge the overdue fees to your credit card that we have on file. If we are unsuccessful in charging your card, we will use a collecting agency to recover non-paid fees, and this will revoke your right to privacy with respect to disclosure in regards to your name, your child's name, address, and services rendered. Your credit card will not be charged for any other reason without your permission.

However, we are here to help. Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship, call (847) 975-5598 for assistance.

Initial: _____

I have read, initialed and have agreed to the financial policies disclosed above.

My Child's Name: _____

My Name: _____

Signature: _____

Date: _____

Credit Card on File Authorization Form

All information will remain confidential.

Registration Information:

Name of Participant: _____

Description of Services and/or Payment: _____

Credit Card Payment Information:

Cardholder Name: _____

Email Address: _____

Billing Address: _____

Credit Card Type: ___ Visa ___ Mastercard ___ Discover ___ AmEx

Credit Card Number: _____

Expiration Date: _____

CVV Code (3 digit # on back for Visa, MC, Discover OR 4 digit # on front for Amex) : _____

I authorize THE TREE HOUSE CENTER FOR GROWTH AND LEARNING to maintain credit card payment information in their secure and confidential files and to use this credit card for weekly payments owed on my account for services rendered at their office. I authorize THE TREE HOUSE CENTER FOR GROWTH AND LEARNING to charge the amount of an unexcused absence. In case of outstanding debt, I authorize the Tree House to bill my account after 45 days of non-payment. I agree that I will pay for this purchase in accordance with the issuing bank cardholder agreement.

Cardholder – Print Name, Sign and Date Below:

Cardholder Signature: _____

Print Name: _____ Date: _____

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY: _____

ID # ON CARD: _____ GROUP: _____

CUSTOMER SERVICE OR MENTAL HEALTH NUMBER ON CARD:

NAME OF PRIMARY INSURANCE HOLDER:

PRIMARY HOLDER DATE OF BIRTH: ____/____/____

NAME OF PARTICIPANT: _____

PARTICIPANT DATE OF BIRTH: ____/____/____

RELATIONSHIP TO PARTICIPANT: _____

ADDRESS OF PRIMARY INSURANCE HOLDER: _____

ADDRESS OF PARTICIPANT (IF DIFFERENT): _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

EMPLOYER: _____

Who is financially responsible for the account? _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I _____, authorize the Tree House Center for Growth and Learning to release information as to my or my dependent's diagnosis and treatment to my insurance company for the sole purpose of validating my claim. I also assign my insurance benefits to my provider and I authorize payment to be made directly to the office by my insurance company.

Signature: _____

INFORMED CONSENT

I consent to allow The Tree House CGL to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

Information related to the scheduling of meetings or other appointments
Information related to billing and payment

Information related to treatment or therapeutic goals

All other information needed for therapeutic treatment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

Your signature below indicates that you have read our Informed Consent agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above.

Printed name of parent or guardian: _____

Signature of parent or guardian: _____

Client/Guardian Date Child (ages12-18): _____

Date: _____

Your signature below indicates that you have read our Informed Consent agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above.

Client/Guardian

Date

Child (ages12-18)

Date

PLEASE DETACH THE REST OF THE PAGES FOR YOUR RECORDS

**The Tree House Center for Growth and Learning
4160 Route 83
Suite 211
Long Grove, IL 60047
(847) 975-5598**

PSYCHOLOGIST/THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to the The Tree House Center for Growth and Learning. This document contains important information about our professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPPA). This is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPPA requires that we provide you with a Notice of Privacy Practices and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next meeting. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke the Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and client, and the particular problems you or your child is experiencing. There are many different methods we may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you may be asked to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of this evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have any questions about our work, we should discuss them as soon as they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

We typically schedule one 50-minute session per week. However, depending upon the circumstances, some sessions may vary in length and frequency. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled session.**

PROFESSIONAL FEES

Our hourly therapy rate is 200.00. The first two sessions are considered as assessments and our hourly rate for these sessions is \$250.00. All phone conversations or written correspondence exceeding 10 minutes will be billed at our hourly therapy rate.

Payment of your bill is expected to be met in a timely fashion. After 45 days of non-payment The Tree House Center for Growth and Learning will use a collecting agency to recover non-paid fees, and this will revoke your right to privacy with respect to disclosure in regards to your name, address, and services rendered.

CONTACTING US

You can contact us at 847.975.5598 We will return phone calls within 24-48 hours Monday-Friday.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA and/or Illinois law. However, in the following situations, no authorization is required.

- I may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot disclose any information without a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If you file a worker's compensation claim, and I am rendering treatment or services in accordance with the provisions of Illinois Workers' Compensation law, I must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to believe a child under 18 known to me in my professional capacity may be an abused child or a neglected child, the law requires that I file a report with the local office of the Department of Children and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that I file a report with the agency designated to receive such reports by the Department of Aging. Once such a report is filed, I may be required to provide additional information.

- If you have made a specific threat or violence against another, I may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.
- If I believe that you present a clear, imminent risk of serious physical or mental injury or death to yourself, I may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.

If such a situation arises, I will make every effort to fully discuss it with you before taking an action and I will limit my disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep PHI about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. I will charge \$0.25 per page.

Your Clinical Record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress toward these goals, your medical and social record, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including your insurance carrier.

PATIENT RIGHTS

HIPPA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS AND PARENTS

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's record unless the child consents and unless I find that there are no compelling reasons for denying access. If I feel that the child is in danger or is a danger to someone else, I will notify the parents of my concern.

We will not testify in court regarding therapy in divorce/child custody proceedings.

COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with staff or therapists at the Tree House Center for Growth and Learning (The Tree House CGL), there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with The Tree House CGL
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with staff at the Tree House CGL about ways to keep your communications safe and confidential.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms here are some definitions:

- **“PHI”** refers to information in your health record that could identify you.
- **“Treatment, Payment, and Health Care Operations”**
 - Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility coverage.
 - Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.
- **“Use”** applies only to activities within our office and practice such as sharing, employing, utilizing, examining, and analyzing information that identifies you.
- **“Disclosure”** applies to activities outside of our office and practice such as releasing, transferring, or providing access to information about you to other parties.
- **“Authorization”** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain authorization before releasing our Psychotherapy Notes. “*Psychotherapy Notes*” are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your record. These notes are given a greater protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse** – If we have reasonable cause to believe a child known to us in our professional capacity may be an abused child or a neglected child, we must report this belief to the appropriate authorities.
- **Adult and Domestic Abuse** - If we have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, we must report this belief to the appropriate authorities.
- **Health and Oversight** - We may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.
- **Judicial and Administrative Proceedings** – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment, and the records thereof, such information is privileged under state law, and we must not release such information without a court order. We can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not

apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- ***Serious Threat to Health or Safety*** – If you communicate to us a specific threat of imminent harm against another individual or if we believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, we may make disclosures that we believe are necessary to protect that individual from harm. If we believe that you present an imminent, serious risk of physical or mental injury or death to yourself, we may make disclosures we consider necessary to protect you from harm.
- ***Worker's Compensation*** – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's and Therapist's Duties

Patient's Rights:

- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.
- ***Right to receive Confidential Communications by Alternate Means and at Alternate Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. On your request, we will send your bills to another address.)
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, we will discuss with you the details of the request for access process.
- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's and Therapist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are not required to abide by the terms currently in effect.
- If we revise my policies and procedures, we will make written notices available to you.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 15, 2003.

We reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice by giving you a copy of revisions.

All files are kept a minimum of 7 years. After this time, all information except a data sheet is shredded. If you are under age 18, the 7-year period does not start until your 18th birthday.