Priscilla Brinkman, LCSW, FT
825 West State Street, Suite 118 Geneva IL 60134
630-471-2117
pbrinkmanlcsw@gmail.com

Informed Consent

Welcome. The following information is intended to help you feel as comfortable as possible and answer some of the questions you may have as we begin therapy. I encourage you to ask any other questions at any time.

As with any treatment, there are some risks as well as many benefits with therapy. Risks sometimes include experiencing uncomfortable or painful feelings such as sadness, anxiety, anger, frustration, or other feelings. These risks are normal and to be expected when people are making important changes in their life. While you consider these risks, you should also know that therapy has been shown to have many benefits that include significant reduction of distress as well as improved relationships and coping skills, increased self-awareness, and the satisfaction of meeting your personal goals.

Appointments and Cancellations: Therapy sessions will typically be on a weekly or bi-weekly basis; duration and frequency vary depending upon the nature of your individual needs. If you need to cancel an appointment, please tell me as soon as possible, but at least twenty-four (24) hours in advance of your reserved appointment time. Please understand that because this time is reserved for you, the lack of adequate notice prevents sufficient time to schedule other clients in need. If you do not provide 24 hours notice of a cancellation, you are responsible for paying the full amount for the session. (If you are using insurance, please note that appointments cancelled with less than at least 24 hours notice, missed or failed appointments are not eligible for insurance benefits and you are responsible for paying the full fee for that session, not just your co-pay amount.) If a last minute problem prevents you from attending an appointment, consider having a telephone appointment at that time.

Confidentiality: In all but a few rare situations, your confidentiality is protected by state law and by the rules of my profession. Information you share with me and all matters relating to your therapy will be kept strictly confidential and will not be disclosed without your written permission to release information to a specific individual or organization, such as another healthcare provider. In addition, if I believe that you are in imminent danger of harming yourself or others, or in any situation in which a child or elderly person is put at risk, such as in the case of sexual or physical abuse or neglect, I am required by law to report that danger. In such a situation, I would talk with you about both my concerns and the action taken, if feasible.

Phone and Emergency Contact: Don't hesitate to contact me by phone. If I am unavailable when you call, please leave a message on my confidential voicemail. I'm usually able to return calls within the day, but there can be unavoidable delays. I will return your call as soon as possible. If you are experiencing an emergency, please call 911 or go to the nearest hospital emergency room.
No fees are charged for phone calls regarding appointments and similar matters; nor are fees charged for phone calls requiring just a few minutes; however, a pro-rated charge will be made for therapy conducted over the phone that require more than 15 minutes. This would be billed at the same rate as private face-to-face therapy.

Insurance Coverage: If you maintain health insurance, part of your therapy expenses may be covered. You are responsible to contact your insurance company to determine insurance benefits. Please be aware most insurance agreements require me to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or, in rare cases, a copy of the entire record. Remember, if fees you expect your insurance company to cover are rejected for any reason, these fees become your responsibility to pay.

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Fees: You are expected to pay for services at each session. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount, as estimated by your insurance quote of benefits. Currently, acceptable forms of payment are cash, credit/debit card (VISA, MasterCard or Discover), or check (payable to "Priscilla Brinkman, LCSW"). **Remember, appointments must be cancelled 24 hours prior to appointment time or you will be charged in full.**

Insufficient funds and delinquent accounts: A $25 charge will be assessed for any check given in payment of your account if the check is not honored at the bank because of insufficient funds. The charge will be added to your balance due and shown on your statement.
Late payments will be subject to a penalty fee of 12%. per anum. Delinquent accounts may be sent to collections if fee payment obligations are not met in a timely manner, an additional 35% will be added to your account if sent to collections.

Ending Therapy: You can end therapy at any point you wish. Usually therapy pursues specific goals and you and I will discuss together an appropriate termination process. If you decide you want to terminate your treatment, but have a scheduled appointment, please call me and explain that you wish to take a break or end your therapy. You are always welcome to call or continue your therapeutic work if you find the need to in the future.

Ethics & Professional Standards: As a therapist, I work to uphold the most responsible, ethical and professional standards possible, and I am accountable to you. If you have any questions or concerns about your course of contact with me, please feel free to discuss these issues with me. In signing this contract you are agreeing that should you have any dissatisfaction(s) or concern(s) about your treatment, that you will do your best to indicate your concerns to me so I can attempt to address them to your satisfaction. If you are unhappy with your services here and need help finding additional or alternate assistance, I will assist you in locating a more suitable referral or therapy resource.

Consent for treatment: I consent to be treated as a client by Priscilla Brinkman, LCSW. My signature below indicates that I have read and understand the information provided in this document and agree to abide by its terms.

____ __________
Signature of Client (12 years and older) Date

____ __________
Signature of Client (Couples/Family Counseling) Date

Consent for treatment of children or adolescents: I/We consent that ____________________ may be treated as a client by Priscilla Brinkman, LCSW. My signature below indicates that I have read and understand the information provided in this document and agree to abide by its terms.

____ __________
Signature of Parent/Guardian (for all children up to 18 years of age) Date

____ __________
Signature of Parent/Guardian (for all children up to 18 years of age) Date

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Client Information

Today's Date____________________

CLIENT ____________________ **(DOB)** __________ **Phone (H)** ____________________

ADDRESS ____________________ **Phone (W)** ____________________

City ____________________**Zip**__________**Phone (cell)**____________________

SS # ____________________ *** E-mail** ____________________

May I send correspondence or leave messages?

Home address YES NO **Cell Phone** YES NO

Home Phone YES NO **Email** YES NO

Emergency Contact Information, Name and Phone

____________________ ____________________

____________________ ____________________

How were you referred to me? ____________________

Billing Information

PERSON RESPONSIBLE FOR PAYMENT ____________________ **(DOB)** __________ **Phone (H)** ____________________

RELATIONSHIP TO PATIENT ____________________**Phone (W)** ____________________

ADDRESS ____________________ **Phone (cell)** ____________________

____

SS # ____________________ **EMPLOYER** ____________________

WILL YOU BE USING YOUR INSURANCE? YES NO

Insurance Co ____________________**Group ID**__________**PolicyNumber**____________________

Secondary Insurance? YES NO ____________________

****A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED**

PRESENTING PROBLEM:

____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996, (HIPAA), effective April 14, 2003, mandates that health care providers inform individuals of their rights with regard to Protected Health Information, (PHI) (information that is personally identifiable; your name, address, phone number, social security number, etc.). To this end I have listed below the individuals who have access to your PHI and the circumstances in which I would use or disclose your PHI:
I will use and disclose PHI for the following reasons:

1. With consent from the Client or Parent should the client be a minor.
2. Where legal regulations explicitly demand disclosure without the client's consent. Client is a danger to self or others, in the case of known or suspected child abuse or neglect, I may inform law enforcement officials, (i.e., Police, Sheriffs Dept., Department of Social Services) and when ordered to by a court order, court ordered subpoena, administrative tribunal, (social security admin).
3. With your consent I will share information to coordinate your care with your primary care physician.
4. At your request I will send service information and diagnosis to your insurance company for claims payment.
5. At your request I will send information regarding your services to selected individuals.
6. In the case of a mandatory employee assistance referral I will, with your consent, send compliance information to the appropriate person at work.
7. The department of Health & Human Services (HHS) can view your PHI as a part of a compliance audit with the HIPAA standards.

The following are your rights to your PHI in my office:

1. Right of Notice – You have the right to read this privacy notice and know how I use my clients' PHI.
2. Right to Protect – You have the right to control the use of your PHI. HIPAA dictates that if you don't wish to give consent for disclosure of your PHI I will not take action against you.
3. Right to Access – You have the right to look at your PHI.
4. Right of Accounting – You get to know where your PHI goes.
5. Right of Amendment – You have the ability to request that the health care provider amend or modify the PHI.

HIPAA also mandates that you be informed that I am not required to honor the previous requests. I will make every effort to comply with your requests.

____________________________________ __________
Signature Date

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Insurance Checklist

Prior to your first visit please call the phone number on the back of your insurance card and ask the following questions:

Client Name: ______________________________Policy Holder: _________________________
Primary Insurance: ________________________Effective Date________________________
Secondary Insurance: ______________________Effective Date________________________

1. What are my benefits for "in network out patient behavioral health"?

   Amount of copay/co-insurance? ____________________

   How many sessions are allowed? ________________________

   Do I have to satisfy a deductible/how much? __________________

   Are there 2 separate levels of benefits? Serious & non-serious? _________

2. Do I need pre authorization before I can be seen by a therapist?

   If yes, what is the authorization # __________________________

   Number of sessions approved ___________________________________

   Name of rep & date of your phone call ____________________________________

3. Is Priscilla Brinkman, LCSW, covered under my benefits package?

   If "No", what are my "out of network" benefits?

   ____

Address where insurance claims should be sent:
____
____
____

Procedure Codes:
90806 – Individual Therapy
90847 – Family Therapy
90853 – Group Therapy

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Assignment of Benefits / Agreement for Payment

I HEREBY AUTHORIZE payment to be made directly to Priscilla Brinkman of any insurance benefits covering my care. I understand as signee I am financially responsible to Priscilla Brinkman for all charges that are not covered by my insurance company.

I give Priscilla Brinkman permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account.

SIGNED: ______________________________ Date:____________________

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Credit Card on File Agreement

It is not my policy to carry balances with my clients. Payment is due at the time of service. Unless prior arrangements have been made, any balance that is past due 60 days, I will automatically charge the balance to your credit card.

Any missed sessions or cancellations without a 24 hour notice will be charged to your designated credit card as well.

Client Name: ___________________________

Credit Card Type: Visa ___ Mastercard ___ Discover ___

Cardholder Name: __________________________________

Billing Address on Card: ______________________________

____

Credit Card Number: ________________________________

Expiration Date: ________ Security Code: ________

I agree to the terms above and authorize you to bill my credit card for unpaid balance due.

_____________________________________ _________

Signature Date