

Psychotherapy Associates of Chicago LLC

Treatment Guidelines and Consent

Independent Contractor Status: Psychotherapy Associates of Chicago LLC is a collection of independently practicing clinicians. Each therapist is solely responsible for his/her behavior and standards of care. Other clinicians in the practice cannot be held liable or responsible in the event of a malpractice claim.

Confidentiality: All material discussed within the session is confidential and cannot be released without client approval. However, the therapist is legally obligated to break confidentiality in the following cases: a client presents a clear and imminent risk to his/herself or others; there is a court-ordered valid subpoena; or the client discloses or there is suspicion of neglect, physical abuse, and/or sexual abuse of minors, persons with disabilities, or the elderly.

Cost and Payment: Our rate is \$110 per session, payable at the time of service. If paying by check, clients should write it in advance in order to make the best use of time. Any adjustments to the fee need to be discussed in advance and cannot be retroactive.

Invoicing: Clients will be sent an invoice for any outstanding debts and are asked to remit payment within 15 days. If our office has not received payment within 45 days, the client's credit card will be billed without additional notification.

Length of session: Sessions will last 45-50 minutes. Additional time will be billed at \$25 for each additional 15 minute increment. This fee will be charged to the credit card at the time of service. Clients are asked to arrive on time.

Cancellation policy: Clients will be charged for sessions cancelled without a 24-hour advance notice. We can make no exceptions to this rule, including for reasons associated with illness, childcare issues, weather, or work conflicts.

Phone/e-mail/report policy: There is no charge for returned calls or e-mails, provided that the contact does not exceed 10 minutes. Additional time, including collateral contacts and writing reports, will be charged on a prorated basis.

Emergency Contact: Therapists are not available on an emergency or "on-call" basis. Clients may leave a message but there may be an extended period of time before the clinician receives it and/or responds. Clients requiring immediate assistance must call 911 or go to the nearest emergency room. If clients require additional support the therapist will provide a referral to an outside agency that can provide emergency staff.

Professional Consultation: In order to ensure proper treatment and professional growth, therapists may meet with other clinicians for case consultations and trainings. Confidentiality will be maintained, however, as no identifying information will be provided. Regardless of consultation, the therapist remains solely responsible for his/her treatment.

Limits of Treatment: There are rare circumstances in which a therapist may be obligated to make a unilateral decision to terminate therapy. Such circumstances include, but are not limited to: the current treatment appears to be ineffective; threats are made against the therapist or his/her family; the therapist does not believe he/she has the necessary training to address a specific problem; or there is a significant therapeutic impasse. In such cases the therapist will attempt to find a suitable referral. The therapist cannot be responsible as to whether this referral is accepted.

Credit Card: To ensure payment, clients are required to provide a credit card or pay at the time of service. This card will be charged in accordance with the policies listed above and without additional notification. A receipt of payment will be mailed following any charge. It is the responsibility of the client to notify the therapist, in writing, if he/she does not want this card charged in the future.

Collections: If the credit card is denied and the client fails to pay for charges within 60 days, the account will be sent to collections. Clients will be held responsible for all collection fees, assessed at an additional 30% of the outstanding balance.

_____ Credit Card Number

_____ Expiration Date

I, _____, have read, understand, have had time to ask questions, and agree to the policies listed above. I agree that I am solely responsible for the cost of my treatment. Additionally, I hereby agree to have my credit card charged for all outstanding debts. I understand that I have the right to end therapy at any time, as well as refuse any suggestions or requests made by my therapist. I understand this consent has no expiration date.

_____ Client or Legal Guardian

Date