

 Oak Brook & Oak Park, IL or virtually for IL residents ~ 630.710.5729 ~ sgosmirelcpc@hotmail.com

**Registration - PLEASE PRINT, COMPLETE, AND TURN IN THESE FORMS BEFORE YOUR FIRST APPOINTMENT**

Date:\_\_\_\_\_\_\_\_\_ Client Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Numbers: Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contacts and Releases**

Parent’s Name, if applicable (if client is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent’s Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on your voicemail?yes or no

Often times email and or text messaging is used to confirm or make appointments. This form of communication is sometimes unsecure. Please sign if you give permission to receive text and/or email.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign to give permission to release information to above-named person in case of an emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like us to contact your primary care or another physician? Yes\_\_ No\_\_**

**If yes, please provide physician’s name and phone number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign to give permission to release information to above-named physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Insurance Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of primary insured person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my consent for Oak Brook Counseling & Wellness providers to exchange information with my insurance company for authorization and reimbursement. I also request of insurance benefits to myself or to Oak Brook Counseling & Wellness.**

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_**

**How did you hear about Oak Brook Counseling & Wellness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Oak Brook ~ Oak Park, IL 630.710.5729

**Consent for Services**

This form is called a Consent for Services (the "Consent"). Your therapist, counselor, psychologist, doctor, or other health professional ("Provider") has asked you to read and sign this Consent before you start therapy. Please review the information. If you have any questions, contact your Provider.

**THE THERAPY PROCESS**
Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review the policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. You may have discussed some of this with the intake coordinator before your appointment and use this time to review and ask additional questions if necessary.

Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

**IN-PERSON VISITS & SARS-CoV-2 ("COVID-19")**
When guidance from public health authorities allows and your Provider offers, you can meet in-person. If you attend therapy in-person, you understand:
• You can only attend if you are symptom-free (For symptoms, see: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html);
• If you are experiencing symptoms, you can switch to a telehealth appointment or cancel. If you need to cancel, you will not be charged a late cancellation fee.
• You must follow all safety protocols established by the practice, including:
• Following the check-in procedure;
• Washing or sanitizing your hands upon entering the practice;
• Adhering to appropriate social distancing measures;
• Wearing a mask, if required;
• Telling your Provider if you have a high risk of exposure to COVID-19, such as through school, work, or commuting; and
• Telling your Provider if you or someone in your home tests positive for COVID-19.
• Your Provider may be mandated to report to public health authorities if you have been in the office and have tested positive for infection. If so, your Provider may make the report without your permission, but will only share necessary information. Your Provider will never share details about your visit. Because the COVID-19 pandemic is ongoing, your ability to meet in person could change with minimal or no notice. By signing this Consent, you understand that you could be exposed to COVID-19 if you attend in-person sessions. If a member of the practice tests positive for COVID-19, you will be notified. If you have any questions, or if you want a copy of this policy, please ask.

**TELEHEALTH SERVICES**
To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:
• Risks
• Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.
• Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.
• Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.
• Benefits
• Flexibility. You can attend therapy wherever is convenient for you.
• Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.
• Recommendations
• Make sure that other people cannot hear your conversation or see your screen during sessions.
• Do not use video or audio to record your session unless you ask your Provider for their permission in advance.
• Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

CONFIDENTIALITY
Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions.
• Your Provider may speak to other healthcare providers involved in your care.
• Your Provider may speak to emergency personnel.
• If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed. There are a few times that your Provider may not keep your personal information confidential.
• If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.
• If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.
• If your Provider believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your Provider will work with you to discuss other options to keep you safe.

RECORD KEEPING
Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

COMMUNICATION
You decide how to communicate with your Provider outside of your sessions. You have several options:
• Texting/Email
• Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.
• Secure Communication
• Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record.
• Social Media/Review Websites
• If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy.
• Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back.
• If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge.

FEES AND PAYMENT FOR SERVICES
You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:
• No-Show and Late Cancellation Fees
• If you are unable to attend therapy, you must contact your Provider before your session. Otherwise, you may subject to fees outlined in your fee agreement. Insurance does not cover these fees.
• Balance Accrual
• Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Your Provider may offer payment plans or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.
• Administrative Fees
• Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.
• Insurance Benefits
• Before starting therapy, you should confirm with your insurance company if:
• Your benefits cover the type of therapy you will receive;
• Your benefits cover in-person and telehealth sessions;
• You may be responsible for any portion of the payment; and
• Your Provider is in-network or out-of-network.
• Sharing Information with Insurance Companies
• If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work.
• Covered and Non-Covered Services
• When your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of therapy. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You may also be responsible for any services not covered by your insurance.
• When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.
• Payment Methods
• The practice requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

COMPLAINTS
If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_

 HIPAA Revised 3/7/2022

**Oak Brook Counseling & Wellness ~ Oak Brook ~ Oak Park, IL ~ 630.710.5729**

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.

Oak Brook Counseling & Wellness (the “Practice”) is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information (“PHI”), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this “Notice”), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

YOUR RIGHTS
Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

To inspect and copy PHI.
• You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee.
• The Practice may deny your request if it believes the disclosure will endanger your life or another person's life. You may have a right to have this decision reviewed.

To amend PHI.
• You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request.
• The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To request confidential communications.
• You can ask the Practice to contact you in a specific way. The Practice will say “yes” to all reasonable requests.

To limit what is used or shared.
• You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your care.
• If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer.
• You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared.
• You can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice.
• You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you.
HIPAA Page 2 • If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.

To file a complaint if you feel your rights are violated.
• You can file a complaint by contacting the Practice using the following information:
Oak Brook Counseling & Wellness
1010 Jorie Blvd. Suite 112
Sabrina Gosmire
630.710.5729
• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
• The Practice will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications.
• The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

OUR USES AND DISCLOSURES
1. Routine Uses and Disclosures of PHI
The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your health information in the following ways:

To treat you.
• The Practice can use and share PHI with other professionals who are treating you.
• Example: Your primary care doctor asks about your mental health treatment.

To run the health care operations.
• The Practice can use and share PHI to run the business, improve your care, and contact you.
• Example: The Practice uses PHI to send you appointment reminders if you choose.

To bill for your services.
• The Practice can use and share PHI to bill and get payment from health plans or other entities.
• Example: The Practice gives PHI to your health insurance plan so it will pay for your services.

2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object
The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

To help with public health and safety issues
• Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.
• Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.
• Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care

Page 3.

system, government benefit programs, other government regulatory programs, and civil rights laws.
• Serious threat to health or safety: To prevent a serious and imminent threat.
• Abuse or Neglect: To report abuse, neglect, or domestic violence.

To comply with law, law enforcement, or other government requests
• Required by law: If required by federal, state or local law.
• Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.
• Law enforcement: For law locate and identify you or disclose information about a victim of a crime.
• Specialized Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.
• National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.
• Workers' Compensation: To comply with workers' compensation laws or support claims.
To comply with other requests
• Coroners and Funeral Directors: To perform their legally authorized duties.
• Organ Donation: For organ donation or transplantation.
• Research: For research that has been approved by an institutional review board.
• Inmates: The Practice created or received your PHI in the course of providing care.
• Business Associates: To organizations that perform functions, activities or services on our behalf.

3. Uses and Disclosures of PHI That May Be Made With Your Authorization or Opportunity to Object
Unless you object, the Practice may disclose PHI:

To your family, friends, or others if PHI directly relates to that person's involvement in your care.

If it is in your best interest because you are unable to state your preference.

4. Uses and Disclosures of PHI Based Upon Your Written Authorization
The Practice must obtain your written authorization to use and/or disclose PHI for the following purposes:

Marketing, sale of PHI, and psychotherapy notes.

You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing
OUR RESPONSIBILITIES
• The Practice is required by law to maintain the privacy and security of PHI.
• The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law.
• The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on the website [WEB ADDRESS WHERE THIS NOTICE IS POSTED].
• The Practice will inform you if PHI is compromised in a breach.
This Notice is effective on 01/24/2022.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 1010 Jorie Blvd. Suite 112 - Oak Brook, IL 60523

 137 N. Oak Park Ave. Oak Park, IL 60137

 Oakbrookwellness.com - 630.710.5729

Headway Welcome Letter

Oak Brook Counseling & Wellness is changing the insurance billing process by using a third-party manager called Headway for those who have Aetna Insurance or United Health Care or a Divisions of United Health Care/Aetna Insurance.

Headway manages everything related to payments and insurance, and clients have found working with Headway to be easy.

They’ll send you an email directly, prompting you to create an account and provide your insurance information and a credit card for your copay or deductible.

 Using Headway will not change your current copay or deductible.

If you have any questions about how Headway works, please feel free to reach out directly to them at hello@headway.co.

They would be happy to answer any questions you may have!

Thank you!

Sabrina Gosmire, LCPC

Practice Manager

630.710.5729

**Oak Brook Counseling & Wellness ~ Oak Park ~ Oak Brook, IL, 630.710.5729**

**Financial Policy Agreement**

The financial policy is important to our professional relationship. Please carefully review the following and let us know if you have questions. This Financial Policy Agreement must be reviewed and signed by the client if 18 years and above and by the individual, if other than the client, who is financially responsible for payment for services by Oak Brook Counseling & Wellness (OBCW).

**Payment and Credit Card**

**Payment.** You are expected to pay the agreed upon fee per hourly session (copay, coinsurance, deductible etc.) after the insurance company provides an explanation of benefits, unless other arrangements have been made in writing. If you are using out-of-network insurance plans or are self-paying, please pay us after receiving our services unless we have another arrangement in writing. We accept cash, credit card, and check. Contact us for reduced fee options.

Initial Intake Session: $175 Individual/Family Session: $160 Reports: $100.00

Phone consultations not reimbursable by insurance:

10 -15 min = $60, 15-30 min = $100 30-60min = $160.00

**Credit Card**. We require you to keep a credit card on file, regardless of how you plan to pay for your sessions. By providing your credit card information, you authorize us to charge unpaid balances, sessions not covered by insurance, and fees of any kind to this card at the time of service or after information has been received from your insurance company. The most common charges include therapy sessions (copay, coinsurance, fee towards the deductible etc.) and cancellation fees. We will save your credit card information in your file for future charges.

If you pay by check and that check is returned to us for any reason, you agree that the following will be charged to your card: your entire balance due, any returned check fees charged to us, and a $50 fee to cover our billing services management of the situation. If you do not provide a valid credit card, any unpaid balances will be sent to collections. Collection agencies may impose additional fees on your bill.

You understand that if you dispute a charge (also called a “chargeback”) through your payment method for any service or missed appointment that such action is considered appropriate for immediate termination from the therapeutic process. Lastly, certain elements of your Protected Health Information may be disclosed during the process of appealing a “chargeback”.

**Overdue Bills and. Collection Agency.** Any overdue bills will be charged 1.5% per month interest. If you do not pay the debt, we reserve the right to give your full legal name, contact information, amount due, and any other pertinent information (including protected health information) to a collection agency. If your account is sent to a collection agency and/or small claims court, you will be responsible for any cost related to OBCW pursuing collection efforts including but not limited to, attorney fees and court costs.

**Insurance**

*Please note that when you or we submit bills to insurance, some personal health information, such as diagnosis, may be revealed.*

You should contact your insurance provider prior to your initial session to verify your benefits as it is your responsibility to be aware of what is and is not covered. Verification of benefits is not a guarantee of coverage until claims are submitted.

By filling out your insurance information on the client portal, you authorize OBCW to send health insurance claims to the health insurance carrier for payment.

A current copy of your valid insurance card and photo ID/Driver’s License is necessary to confirm proof of insurance. If there is failure to provide this information, in a timely manner (within 30 calendar days), you will be responsible for the balance of your claim and any balance due will be immediately processed.

While most insurance plans cover mental health treatment, it is the client’s responsibility to be aware of what is and is not covered. Any benefits verification at the beginning of treatment is a courtesy and any quoted coverages are not guaranteed. Most insurance agreements require you to authorize your therapist to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or additional protected/private health information to successfully process claims. The information provided will become part of the insurance company’s files, and some of it will most likely become computerized. The therapist has no control over, or knowledge of what insurance companies do with the information submitted, or who has access to the information.

If an insurance company requests records from your therapist, your therapist is not required to share any diagnostic information with your insurance provider without a release of information. However, if records are not shared, reimbursement may be suspended or cancelled.

Please note that not all issues/conditions/problems which are dealt with in psychotherapy are reimbursed by insurance companies. Please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future capacity to obtain health or life insurance. In some cases, insurance companies may share information with a national medical information data bank. The accessibility to the companies’ computers or to data banks databases is always in question as computers are inherently vulnerable to hacking and unauthorized access.

**In-Network**. We are in-network with: Blue Cross Blue Shield PPO, Blue Choice PPO, Aetna, and Optum/United Healthcare PPO, Cigna, Medicare, and Humana insurance plans.

If the insurance does not cover your sessions after submission, you will be responsible for the full session fee. If your insurance company issues you a check to pay for a session, please sign it over to us and give it to your therapist within two weeks of the issue date; otherwise, your credit card on file may be charged the check amount.

If you check benefits with your insurance, you will ask about in-network or out of network benefits under “Oak Brook Counseling & Wellness.” If you need the practice billing National Provider Identifier, please inquire about it with your clinician.

**Out-of-Network**. If out-of-network insurance is used, full payment is due at the time of service. We can provide a monthly statement to submit to your insurance company for reimbursement. If you decide to file your claims for out-of-network reimbursement, your insurance may not cover these services, or it may consider them to be subject to lower out-of-network benefits. We do not guarantee that your insurance will cover our services. Your insurance company will not pay some fees, such as late cancellation fees, and these fees will be your sole responsibility to pay.

**Insurance Changes**. If you pay with insurance and your insurance changes, we will work with you to determine your future coverage and, if necessary, refer you to another therapy practice. It is your responsibility to inform us of any changes to your insurance at least 30 days before those changes take effect.

**Billing**. Oak Brook Counseling & Wellness handles the billing internally or uses Headway company for United Health Care or Aetna insurance plans. See the Headway welcome letter. The practice owner or Headway submits claims to the insurance company. The registration coordinator gives a courtesy quote of benefits during the registration call if the insurance information is available.  Feel free to contact her if you need help with billing concerns and insurance verification. You may be contacted by Sabrina Gosmire to address any admin, billing, or financial concerns. For any questions about billing, you may contact her at: (630)710.5729 or sgosmirelcpc@hotmail.com

**Cancellation Policy**

Consistency is key to getting the most out of therapy. If you need to cancel or reschedule, please contact us during business hours and *at least* 24 hours before your scheduled appointment to avoid a late cancellation fee equivalent to the full cost of your session or contracted rate from insurance which ranges from $99 - $160.00. For Monday appointments, you must cancel by 12:00 p.m. on the previous Friday so we can offer that time to another client. If you do not log on, or if you cancel with less than 24 hours’ notice, you may incur a fee of the full cost of your session. Insurance companies do not reimburse for missed sessions or cancelled appointments. If you are late to an appointment, your therapist will wait for you for up to 10 minutes beyond the schedule time. If there is no notification within 10 minutes, it will be considered a missed appointment.

**Additional Notes**: Your digital signatures is authorization that you have agreed to all bullet points below. The words, I, me, my, you and your all refer to the client:

* + I agree to be financially responsible for payment of Oak Brook Counseling & Wellness (OBCW) services. Credit cards are acceptable forms of payment for these services;
	+ I understand clients using insurance that copayments, coinsurance, and deductibles are non-negotiable and cannot be waived regardless of financial situation;
	+ I understand if my financial situation changes I will inform OBCW immediately;
	+ If OBCW, is out of network with my insurance company, I understand OBCW, can provide a SuperBill for full, or partial, reimbursement by my insurance company, but only if I request such service;
	+ I understand if an insurance claim is retroactively denied, at any point, that I am financially responsible for full payment of claims denied for any reason;
	+ I understand OBCW, does not retroactively honor payment adjustments;
	+ I understand that I am responsible for providing accurate insurance information and that OBCW does not retroactively bill for dates of service where it was once considered self-pay and/or out-of-network and is now considered in-network;
	+ I understand that if I fail to pay the balance on my account this may result in OBCW pursuing any collection means possible and that that such action is considered appropriate for immediate termination from the therapeutic process;
	+ I understand that if I dispute a charge through payment method on file for any service or missed appointment that such action is considered appropriate for immediate termination from the therapeutic process;

My signature below acknowledges that I have read and understand the terms of Oak Brook Counseling & Wellness Financial Policy Agreement and my financial responsibilities hereunder. I further agree to keep a valid and current credit card on file at all times. By signing below, I also agree to the terms and conditions set forth herein and have received a copy of this form for my records.

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Security code \_\_\_\_

Expiration Date\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_