Life Point Child & Family Therapy

495 N. Riverside Dr., Ste 208
Gurnee, IL 60031
224-208-5228
LifePointTherapy.com

# Welcome!

The forms and information in this document are helpful to complete before our first meeting. We will discuss them and any questions you have can be answered at that time.

First Appointment:

- Please bring completed paperwork to your first session and retain a copy of this information for your records.
- Insurance Card and ID
- Form of payment and credit card to keep on file
- Please wait in the waiting room and therapist will come to you

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# Your Privacy Information. Your Privacy Rights. Our Privacy Responsibilities.

**This notice is a summary how mental health records and information about you may be used and disclosed and how you can get access to this information. Your rights are established pursuant to HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the law exceptions provide therein. Please review it carefully.**

**YOUR RIGHTS**

You have the right to:

- Get a copy of your paper or electronic mental health record
- Correct your paper or electronic mental health record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**YOUR CHOICES**

You have some choices in the way that we use and share information as we:

- We may not disclose any mental health records or information except as provided under HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein.
- We may not tell you any third party family and friends about your condition except as provided for in the above identified laws. For example: only pursuant to a valid subpoena, release of information, pursuant to the Abused and Neglected Child Reporting Act, and under certain other circumstances of immanent risk of harm.

**OUR USES AND DISCLOSURES**

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Work with a medical examiner or funeral director
- Address certain workers' compensation, law enforcement, and other government requests and subject to certain conditions
- Respond to lawsuits and legal actions

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**YOUR RIGHTS**

When it comes to your health information, you have certain rights. This section explains your rights and some off our responsibilities to help you.

- Get an electronic or paper copy of your mental health record
- You can ask to see or get an electronic or paper copy of your mental health record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your mental health record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests. Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will included all the disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice.
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you
- If you have given someone mental health power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information
- We will make sure the person has this authority and can act for you before we take any action
- File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.

**YOUR CHOICES**

For certain health information, you can tell us your choices about what we share. If we have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

**OUR USES AND DISCLOSURES**

**How do we typically use or share your health information?**

Subject to HIPAA, the Illinois Mental Health and Developmental Disabilities Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein, we typically use or share your health information in the following ways

- **Treat you**
- **Run our organization**
- **Bill for your services**
- **We can use and share your health information to bill and get payment from health plans or other entities.**
- **We may contract with business associates to do work directly for us related to your treatment; this may include billing, consultation, legal, and related business practices. In such circumstances, the business associate will be subject to a Business Associates Agreement which obligates any such associate to maintain privacy consistent with the state and federal requirements outlines herein.**

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html, and the Illinois Mental Health and Developmental Disability Confidentiality Act, state and federal alcohol and substance abuse privacy laws and the exceptions provided therein.

**Subject to certain exceptions, we can share health information about you for certain situations such as:**

- **Preventing disease**
- **Helping with product recalls**
- **Reporting adverse reactions to medications**
- **Reporting suspected abuse, neglect, or domestic violence**
- **Preventing or reducing a serious threat to anyone's health or safety**

**OUR RESPONSIBILITIES**

- **We are required by law to maintain the privacy and security of your protected health information.**
- **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
- **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
- **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be availbale upon request, in our office and on our website.

- The effective Date of this Notice is October 1, 2017
- The privacy official:

  LifePoint Child & Family Therapy including all contracted individuals
  495 N. Riverside Dr, Ste 208
  Gurnee, IL 60031
  Kristin@lpcft.com
  LifePointTherapy.com

- We never market or sell personal information

**SESSIONS**
Individual, family, and couples sessions are typically scheduled for 50 minutes at a frequency to be determined by therapist and client. Intake sessions are typically a little longer depending on therapist, between 60-80 minutes. Group sessions are 90 minutes. Child sessions are shorter depending on attention length, and many times the remaining time is spent connecting with caregivers.

***eSessions***
Sessions are available online via secure video connection. Suggestions for these types of sessions are as follows:

1. Use a quiet, private space to minimize distractions
2. Have a consistent and adequate internet connection
3. Have an in-person initial session and sporadically throughout treatment
4. Understand that while our secure video program is an encrypted connection, there is some risk that confidential information is not private.
5. Must sign eSession release form separately.

**COST OF TREATMENT AND PAYMENT POLICY**
LifePoint Therapy sees clients on a fee-for-service basis. The cost for each session varies with therapist. Please discuss this and complete fee agreement lines below.

The client is responsible for payment in full at the time of each session via personal check, cash, or credit card. Our policy is for each person receiving counseling services to pay for such service at the time the services are rendered. Any other arrangements must be made in advance. eSessions are billed the same as a face-to-face session and the fee is collected prior to session and has a separate consent form.

A $30 administrative fee will be charged on all checks that are returned for non-sufficient funds.

Additional fees apply for: phone calls more than 7 minutes, requested reports or letters, requesting Protected Health Information, legal fees (eg: Attorney fees charged to therapist, time spent in court, etc) and other court fees, as well as other nondescript items for which therapist uses her time on client's behalf also apply.

**CANCELLATIONS**
We understand that it may at times, be necessary to cancel an appointment. To help us be most efficient and responsible in the use of our time, we require that any changes or cancellations be made at least 48 hours in advance. A full session fee is charged for missed, cancelled, or changed appointments with less than a 48-hour notice unless it is due to serious illness or an emergency. The credit card kept on file will be charged for any missed, late cancel or rescheduled appointments less than 48 hours. This is an enforced policy and appreciate your understanding and cooperation.

**TEXTING & EMAIL COMMUNICATION**
Texting and email communication are only used for scheduling and coordination purposes; voicemail is the safest way to share clinical information. Therefore, by reading this and signing, I agree that LifePoint nor any of its contractors will be held responsible for use of text or email communication resulting in a negative outcome. I also understand that email and texting are not HIPAA compliant and any medical or clinical information shared over these avenues is not confidential.

**Please see "How to Communicate with your Therapist" flowchart for helpful guidance on when and how to reach your therapist**

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**INSURANCE**
Many insurance plans reimburse for some portion of psychotherapy. Please direct questions about reimbursement amounts and timeliness to your insurance company. Please inquire about specific details for your insurance situation.

Please check your coverage carefully by asking the following questions:

- Do I have mental health insurance benefits?
- What is my deductible and has it been met?
- How many sessions per year does my health insurance cover?
- What is the coverage amount per therapy session?
- Is approval required from my primary care physician?

**Check and initial if using Insurance agreeing to below statement**

☐ _____

By checking the box above and initialing, I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I understand that insurance benefits are not fully knowable until a claim is submitted and it may be different than what was originally discussed. I also understand that I am responsible for full service fees if my insurance company does not pay for any reason. I agree that the insurance information I entered to register is true to the best of my knowledge. I authorize LifePoint Therapy, those acting on the practices behalf, and my insurance company to release any information required to process my claims. Furthermore, I have reviewed the notice of privacy practices provided. I fully understand and except the terms of this consent. I agree to charging the credit card on file for any remaining balances after insurance claims are paid by insurance payer.

- Late cancellations and missed appointment fees are charged the day of the missed appointment and are not covered by insurance.

**FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT**
I have been informed of and understand the preceding information and agree to it. I, _____, authorize treatment of _____ (client) by LifePoint Child and Family Therapy therapist, and agree to pay $_____ for initial assessment sessions (typically first three sessions), and $_____ for ongoing 50 minute sessions.

I also agree for any session fees to be charged to credit card kept on file if I do not pay at the time of the session.

**TERMINATION**
At any time I may decide to cease services. LifePoint kindly requires at least two termination sessions to bring closure to the time in treatment, given the nature of counseling and being based on relationship. This allows for celebration of progress made and healthy closure to the relationships built.

_____ _____
Client or Minor (aged 12 & older) Date Printed Name

_____ _____
Parent and/or Legal Guardian Date Printed Name

_____
Therapist Date