*Charu Chandra, LCPC*
*1142 Chicago Ave. Suite 2 E, Oak Park, IL 60302*
*Phone: (312) 479-4779, Fax: (*708) 779-6131

# Consent and Service Agreement

Welcome to your first session at my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Please review carefully. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

**About Counseling Services**
Psychotherapy has both benefits and risks. The potential benefits of counseling are many and include improved personal functioning, relationships, self image, mood and the attainment of personal goals. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Clients understand that healing and growth is difficult, and some discomfort will likely be a part of the counseling process.

Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever 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.

**Confidentiality**
Personal Health Information All communications and records with your counselor are held in strict confidence. Information may be released, in accordance with state law, when (1) the client signs a written release indicating consent to release; (2) the client expresses serious intent to harm self or someone else; (3) there is reasonable suspicion of abuse against a minor, elderly person, or dependent adult; (4) to acquire payment for services or for billing purposes, or (5) a subpoena or court order is received directing the disclosure of information. To protect your privacy to the greatest extent of the law, it is our policy to assert either (a) privileged communication in the event of #5 or (b) the right to consult with clients, if at all possible, before mandated disclosure in the event of #2 or #3.

**Electronic Communication**
Electronic communications, both telephone and Internet (including email), are not secure methods of communication, and there is some risk that one's confidentiality could be compromised with their use. Counselors sometimes communicate with clients using these mediums. If you would prefer to not be contacted by telephone or email, please inform your counselor and we will honor this request.

**Client Follow up**

Your counselor may "follow up" with you after counseling / life coaching has ended. 1 month, 3 month, or 6 month follow up calls may be made to check in with clients and see if gains made in counseling have been

maintained. If you would prefer that I do not contact you, simply let me know and your preferences will be respected.

**Appointments**
Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less and as frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours notice. If you miss a session without canceling, or cancel with less than 24 hour notice, my policy is to collect the amount of your payment [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 canceled sessions; thus, you will be responsible for the portion of the fee as described above. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

**Professional fees**
Payment is due at the time of your scheduled session. Any insurance co-pays or deductibles are due at the time of the session. The standard fee for the initial intake is $175.00 and each subsequent session is $145.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; credit card payments will incur an additional 3% processing fee. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. Unfortunately, we can't extend credit or provide services until payment is made. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

Charu Chandra, LCPC keeps a credit card number on file for each client in case there is an outstanding account balance which has not been paid. In the event your credit card is used to pay off your account, you will be charged the full amount that remains unpaid which may include a late fee. Fees are subject to change without notice.
Credit card type: Mastercard Visa Discover Name on card: _____
Expiration Date: _____
Credit card number: _____
Three Digit Card Code (located on back of card): _____
Initials: _____

**Insurance**
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.
You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information database. I will provide you with a copy of

any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract. If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

**Professional Records**

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

**Emergency Contacts**

I will establish emergency contacts for you, such as phone numbers and location of a family member. I will also obtain alternative methods for contacting you, such as mobile phone, or work phone number. These emergency contacts may be used if I perceive a need.

**Contacting Me**

I am often not immediately available by telephone. At these times, you may leave a message on my confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, please go to your Local Hospital Emergency Room, or call 911 and ask to speak to the mental health worker on call. I will make every attempt to inform you in advance of planned absences.

**Work Agreement**

This is expected that you will engage in the counseling process as an important priority in your life. If you are not satisfied with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

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ACKNOWLEDGEMENT AND ACCEPTANCE I acknowledge that I have received and reviewed this agreement in its entirety. My signature below indicates my acceptance of and agreement to all of its terms.

Signature of Client or Personal Representative _____

Printed Name of Client or Personal Representative _____

Date _____

Description of Personal Representative's Authority: _____