INFORMED CONSENT

Thank you for choosing Essence Lee, MA, LCPC. Today's appointment will take approximately 45 – 55 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Essence Lee, MA, LCPC has earned a Bachelor of Science Degree in Clinical Psychology and a Masters Degree in Human Development Counseling from the University of Illinois at Springfield. She is licensed by the State of IL as a Licensed Clinical Professional Counselor. She has over 4 years of clinical experience in treating adults and families using individual and family therap. Essence Lee practices standard Cognitive Behavioral Therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then I am mandated to report you to the Department of Human Services e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client feels immediate attention is necessary, please call the office and if the office is unavailable please call 911 or report to the nearest hospital. Essence Lee will follow up on those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.*

Signature(s)_____Date:_____

FINANCIAL/INSURANCE ISSUES: *As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Essential Clinical Counseling Services, LLC.*

I have received a copy of my fee schedule _____

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. ***You may have a copy of this form if requested.***

Signature(s)_____Date_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Signature(s)_____Date_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.*

Signature(s)_____Date_____

May we contact you at home (circle one) ***yes no****? May we contact you at work* ***yes no?*** *May we contact you by cell phone* ***yes no?*** *Where may we contact you _____?*