

Advanced Counseling and Assessment Services

General Policy Statement

Confidentiality

According to Illinois or federal law, all sessions are confidential except where identified legal limitations apply or with written consent.

There are three exceptions to this law; danger to self, danger to others, or any form of child/elder abuse or neglect.

Each therapist of ACAS is required by law to respond responsibly to prevent harm to you or anyone else. Each therapist is also required by law as a mandated reporter to report suspicion of child and / or elder abuse.

Please feel free to discuss this issue with your therapist if you have any questions.

Financial Requirements

A full session, 45 minutes, is \$150.00 and payment is due at the time of service by check, cash, or credit card.

Insurance is accepted and ACAS will work with your primary insurance company to determine benefits. Many insurance policies have deductibles, which are the responsibility of the patient and need to be met prior to the patient paying the co-pay for each session. The co-pay is the amount of money which your insurance company does not cover toward the visit. This amount is to be paid at each visit and is your responsibility

As a client of Advanced Counseling and Assessment Services, I am aware my responsibilities include:

- attending sessions as scheduled.
- paying **fee at the time of service.**
- being charged and being **responsible to pay a \$150.00 fee**, which is not covered by insurance, when I fail
 - to **give a 24 hour notice** when canceling an appointment
 - to **give a 48 hour notice** when canceling a Monday appointment.
 - to **show for a scheduled appointment.**
- paying \$60.00 charge for returned checks.

I understand ACAS reserves the right to pursue collection of delinquent accounts. I understand that in the event my account is sent to collections, I will be responsible for all collection costs and legal fees.

Therapist and Client Agreement

The psychotherapeutic counseling relationship is an interactive process between client and therapist involving the client's right to have the following information explained:

- condition or diagnosis.
- the nature and purpose of treatment.
- risks and potential consequences of treatment, including refusing treatment, and consequences of doing so.
- the alternatives to treatment, including refusing treatment, and the potential consequences of doing so.
- the right to include/exclude your family or significant other/s in treatment, to the extent permitted by law.

I grant permission and give consent to the therapist of Advanced Counseling and Assessment Services to provide psychotherapeutic counseling services to me and/or my child. I understand this counselor is not providing an emergency service and is not immediately available/on call during non-office hours. In an emergency I agree and understand my need to seek my local emergency services.

Signature

Date

Please see reverse side for additional consent for treatment of a minor.

Advanced Counseling and Assessment Services
Consent for Treatment of a Minor / Child and Therapist Litigation

Name of Client: _____ Date of Birth: _____ Date: _____

Consent for Treatment of a Minor

I hereby authorize the therapist of ACAS to provide counseling / treatment to the above identified minor.

I give this consent as the client's custodial parent or legal representative.

I understand the therapist is able to share with me the following information without authorization from the client:

- Current mental condition/status
- Diagnosis
- Treatment needs/recommendations
- Times and dates of service
- Billing/Insurance/Payment information

For clients under age 12, the parent or legal representative has the right to all treatment information.

For clients aged 12-18, the parent or legal guardian has the right to access only the information listed above, unless the client gives verbal permission or signs an authorization specifically releasing more information.

I understand I may revoke this consent at any time by giving written notice to the therapist.

Printed name of custodial parent or legal representative	Relationship to client
Signature of custodial parent or legal representative	Date
Therapist's Signature	Date

Child of Divorce and Child/Therapist Litigation Agreement

As the therapist you have chosen to work with your child during this difficult time, it is important to establish certain limits regarding the therapist's role in your child's life. The following limitations must be agreed upon as your child's therapist works with your child in order to enhance the therapeutic work and develop a positive, open relationship:

1. The role of your child's therapist is to create a therapeutic and safe environment for the sharing of feelings related to his or her entire family system, including the divorce. It is understood that the therapist's neutrality in any post-divorce settlement dispute is for the benefit of your child.
2. The therapist can provide you with interventions and strategies to enhance your child's mental and emotional health but will refrain from any comments regarding the other parent.
3. Once therapy begins, your child's therapist will not speak with either of your attorneys, nor appear in court proceedings related to the divorce/custody settlement or visitation disputes.
4. In the event that phone calls or reports related to the divorce are provided by the therapist, time spent on these activities will be billed at our normal hourly rate. Insurance does not pay for these services.
5. It is understood that your child's therapist cannot be called to testify with matters regarding the therapeutic relationship and in circumstances of child custody, visitation, etc. the therapist is and will be identified as an incompetent witness.
6. If any courtroom involvement or testimony is sanctioned or utilized as a deposition it is understood both parents are liable for any accrued fees, including counselor legal representation and hourly rate for time spent.

This agreement is in the best interest of establishing a supportive and therapeutic relationship with your child and must be agreed upon for continuance of counseling services.

Signature of Father	Date
Signature of Mother	Date