Brendan Bell & Associates, Ltd.
Counseling Services

CLIENT INFORMATION

Which therapist will you be seeing? _____ Date _____

Client Name_____

Date of Birth _____

Gender: M_____ F_____ Marital Status: Married_____ Single_____ Other_____

Address_____

City_____ State_____ Zip Code_____

Phone (H)_____ (C)_____

(W)_____

Email _____

May we leave a message on: Email_____ (H) Phone_____ (C) Phone_____

Appointment Reminders (choose one): Text_____ Email_____ (H) Phone_____ (C) Phone_____ Cell Carrier _____

How were you referred to Brendan Bell & Associates?

_____

Name of Parent or Guardian—if client is a minor or dependent

_____

Relationship to Client _____ Phone _____

BILLING INFORMATION

Name of Insurance Company _____ Cardholder's Name

_____

Employer _____Cardholder's Date of Birth _____

Relationship to Client _____

Insurance ID# _____

Group# _____

**A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED

If the client is a minor or dependent, please provide the contact information for the person responsible for payments:

Name: _____

Address_____

City_____ State_____ Zip Code_____

Phone (H)_____ (C)_____
(W)_____

Family Physician _____ Physician's Phone _____

Previous Therapy _____

Presenting Problem

_____

_____

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Client Acknowledgement & Informed Consent

Client Name: _____ Date: _____

Confidentiality

Under state and federal law, matters discussed with your psychotherapist are confidential unless exceptions exist under the law. In most cases, in order to release any information related to your treatment, we will require you to sign a release of information. During therapy, you may request that some information be discussed with another person (i.e., your physician, spouse/partner, children, parents, etc.). If you desire that information be communicated about you to someone else, please ask for a release of information form. If we feel that it will be useful to you, during the therapy process, to discuss your progress or situation with another person (i.e., your physician), you will be asked for your written permission to do so. Please refer to your HIPAA Notice of Privacy Practices for additional information regarding your rights as to the release, use and disclosure of your protected health information.

Please note, the release of confidential information, even without your permission, is required in situations of suspected child abuse, potential harm to oneself or others, and in instances where your records are subpoenaed by proper court order. Please refer to below paragraphs regarding Mandated Reporting and Duty to Warn.

Appointments

Therapy sessions will typically be on a weekly or bi-weekly basis. Additional appointment times can be arranged on an "as needed basis." A therapy "hour" is 45 minutes in duration and may be referred to as a "clinical hour."

Cancellations & Missed Appointments

It is requested that you provide advance notice of cancellation at least 24 hours before your scheduled appointment. If a cancellation has not been made prior to this time, the session is a loss for someone else wishing to use that therapy time. These late cancellations will be billed as a missed appointment at your regular session fee. Remember that some insurance policies do NOT cover missed appointments, so any such charges will be solely the client's responsibility. As such, we require all clients to keep a credit card on file that may be used in the instance an appointment is missed without the required advance notice. Scheduling an appointment means that it will be held only for you and, therefore, cannot be used by another person. If you are late, the session will still end at the normal time.

Children in Waiting Room

We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make other arrangements for childcare during therapy sessions. Parents who do not comply will risk the cancellation of their designated appointment. Parents will be held responsible for any property damage caused by their child.

Telephone Calls

Phone calls may be made at any time for emergencies. No fees are charged for phone calls regarding appointments and similar matters; nor are fees charged for phone calls requiring just a few minutes; however, a pro-rated charge will be made for psychotherapy or psychotherapeutic consultations conducted over the phone that require more than 5 minutes. This would be billed at the same rate as private face-to-face therapy.

Fees

You will be billed for all time spent with you or on your behalf including, but not limited to, therapists' time spent preparing reports, reading letters and documents, consultations, travel time for "out of office" services, and telephone calls. A list of diagnostic testing fees is available by request. Payment is requested at the time of each session either by cash, check, or credit card.

Insurance Coverage

If you maintain health insurance, part of your therapy expenses may be covered. You must check your policy or call your company. Your therapist will discuss with you insurance coverage, requirements and updates.

In order to pay with insurance, you must complete the Insurance Checklist Form prior to your first visit in order to identify covered services and benefits. If your insurance policy does not cover the necessary services, or you do not receive prior authorization as required by your insurance company, or such authorization has not been timely obtained or has been denied by your insurance carrier, you agree that you will be responsible for the entire payment for services and may be billed as a private/self-pay. Further, you understand that you are responsible for and agree to pay any copayments, deductibles, co-insurance, non-covered services or amounts in excess of your health insurance policy's annual and/or lifetime maximum benefit and understand that any such payment is due at the time of services.

Bounced Checks

A $25.00 charge will be assessed for any check given in payment of your account that is not honored at the bank due to insufficient funds or for any other reason. This fee will be added to your balance due and shown on your statement.

Delinquent Accounts & Collection Matters

Late payments will be subject to a penalty fee of 12%. Delinquent accounts that could not be charged to the credit card on file may be sent to collections if fee payment obligations are not met in a timely manner. If collection efforts are required to resolve your account, you agree to reimburse us the fees for any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees.

Ethics & Professional Standards

As psychotherapists and professionals, we work to uphold the most responsible, ethical and professional standards possible, and we are accountable to you. If you have any questions or concerns about your course of contact with us, please feel free to discuss these issues with us. In signing this contract you are agreeing that should you have any dissatisfaction(s) or concern(s) about your treatment, that you will do your best to indicate your concerns to us so we can attempt to address them to your satisfaction. If you are unhappy with your services and need help finding additional or alternate treatment, we will assist you in locating a more suitable referral or therapy resource.

Mandated Reporting

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and

Family Services (DCFS). Your psychotherapist is a mandated reporter, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the mandated reporter the law absolutely requires that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of this office to first advise the client that the report will be made. Subsequent to a "mandated" report, the client, and possibly others, will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded." The mandated reporter has no choice but to make reports in these situations. The client should be aware that the statute provides for loss of license if a mandated reporter fails to make a mandated report. The statute also provides the mandated reporter with absolute immunity from any criminal or civil liability in the event that such a report is made, even without the consent of the client.

Duty to Warn

Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the psychotherapist may "warn" any intended victim, as well as the responsible authorities, and disclose confidential information, where a client discloses in session that he or she intends to cause serious mental or physical harm to a specifically identifiable victim and presents a clear and imminent risk of harm**.** It is then the psychotherapist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring and/or in order to prevent a serious threat to public safety. Therefore, if a client discloses an intent to harm a specific person, the psychotherapist must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

Caution: Psychotherapy May Be Upsetting

Be hereby forewarned and cautioned that engaging in psychotherapy may involve experiencing uncomfortable past traumatic events and/or difficult intense emotions such as depression, anger, grief, confusion, or anxiety. It may also result in changes in your life that could be difficult to face. Further, please note, there are no guarantees that psychotherapy or any therapeutic intervention will yield positive or intended results.

Ending Therapy

You can end therapy at any point you wish. Usually therapy pursues specific goals and you and your therapist will discuss together an appropriate termination process. If you decide you want to terminate your treatment, but have a scheduled appointment please be notified you will be billed and held responsible to pay if you fail to call and cancel the appointment at least 24 hours before the scheduled date and time.

Notice of Privacy Practices

I, the undersigned, acknowledge that I have received Brendan Bell & Associates Notice of Privacy Practices (NPP), and I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer as designated on the NPP.

Please ask before signing below if you have any questions about our psychotherapy or our office policies. Your signature indicates that you have read and understand our office policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate your therapy if you do not comply with the policies or if your therapist feels you are not benefiting from treatment.

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

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HIPAA Notice of Privacy Practices Acknowledgement of Receipt

By signing below, I acknowledge that I have received the Brendan Bell & Associates Notice of Privacy Practices ("NPP"), and that I have read the NPP and understand the information contained in this notice. Further, I understand that I may request a copy of this notice at any time and if I have any questions regarding this notice, I may contact the privacy officer as designated on the NPP.

CLIENT: _____ Date: _____

PARENT/GUARDIAN: _____ Date: _____

620 W. Roosevelt Road, Suite D-1

Wheaton, IL 60187

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INSURANCE CHECKLIST

Prior to your first visit, you must call the phone number on the back of your insurance card and follow these steps to identify your insurance benefits:

Patient Name: _____
Policy Holder: _____
Primary Insurance: _____

1. Give the Insurance representative the Tax ID # 26-1834131. For Blue Cross Blue Shield policies, use the NPI numbers listed below:

□ **Brendan Bell, MA, LCPC**	**NPI # 1003979022**
□ **Melody Cline, MA, ALMFT**	**NPI # 1245686807**
□ **Carissa VanSchooten, MA, ALMFT**	**NPI # 1285082370**
□ **Sharon Bryant MA, LMFT, RPT**	**NPI # 1831582345**

2. What are my benefits for "in-network outpatient behavioral health"?

Amount of co-pay/co-insurance? _____
How many sessions are allowed? _____
Do I have to satisfy a deductible/how much? _____
Are there 2 separate levels of benefits? Serious & non-serious? _____

3. Do I need pre-authorization before I can be seen by my therapist?

If yes, what is the authorization # _____
Number of sessions approved _____
Name of rep & date of your phone call _____

4. Is my therapist covered under my benefits package?

If "No", what are my "out of network" benefits? _____

5. Insurance company claims address:

_____
_____
_____

Common Procedure Codes:
90791—Initial Appointment (45)
90834—Individual Therapy (45)
90847—Family Therapy (45)

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE payment to be made directly to Brendan Bell & Associates of any insurance benefits covering my care and treatment. I understand, as signee, I am financially responsible to Brendan Bell & Associates for all charges that are not covered by my insurance company. I also give Brendan Bell & Associates permission to release any of my health information obtained during examinations or treatment that may be necessary to support any insurance claims. Further, by signing below, I acknowledge that Brendan Bell & Associates is not responsible for securing authorization or coverage by my insurance carrier for my treatment and services, and I understand that Brendan Bell & Associates cannot be held liable for any limitation of coverage or declined authorization by my insurance policy.

SIGNED: _____ **DATE:** _____

THERAPIST: _____ **DATE:** _____

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CREDIT CARD ON FILE AGREEMENT

Please be advised of the following terms of our Financial Policy Agreement:

Outstanding Bills: It is not our policy to carry balances with our clients. Payment is due at the time of service. Unless prior arrangements have been made, if for any reason you should have a balance that is sixty (60) days past due, we will automatically charge the balance to your credit card on file.

Please initial:

_____ Charge Co-pays, Co-Insurance and/or Deductibles per session

Missed Sessions: Any missed sessions or cancellations without a 24 hour notice will be charged to your designated credit card.

Client Name:_____

Therapist Name:_____

Credit Card Type: Visa ◯ Mastercard ◯ Discover ◯

Cardholder Name: _____

Billing Address on Card:

_____

_____

Credit Card Number:

_____

Expiration Date: _____ Security Code: _____

I agree to the terms above and authorize you to bill my credit card for unpaid balances due.

_____ _____

Signature Date

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COMMUNICATION WITH PROFESSIONAL REFERRALS

If you were referred to Brendan Bell & Associates by another professional (doctor, psychiatrist, school counselor, occupational therapist, police department, etc.), do you give us permission to:

- ☐ Notify the professional that we accepted the referral
- ☐ Consult with this professional in regard to your case

Please note, you will be required to complete our release of information form for us to communicate with any professional listed below.

WHO REFERRED YOU: _____ PHONE: _____

SIGNED: _____ DATE: _____

PARTICIPATION IN OUR MAILING LIST

I would like to receive occasional emails from Brendan Bell & Associates that provide announcements, information about new services, seminars, and promotions. I may elect to stop receiving these emails at any time by simply unsubscribing to the emails.

EMAIL ADDRESS: _____

SIGNED: _____ DATE: _____