Solid Foundations Therapy, Inc

5201 Washington St, Suite 2, Downers Grove, IL 60515 *(630) 633-8532*

Client Information Sheet

1.**Name(s)** (First, Middle Initial, Last) **Birth Date** **Social Security #**

_____ _____ _____- _____- _____

_____ _____ _____- _____- _____

2.**Address:**_____

Street City State, Zip Code

3.**Phone numbers:** ( ) _____ - _____ (mobile) Leave message: Yes No

( ) _____ - _____ (mobile) Leave message: Yes No

4. **Email:**_____

5. **How did you hear about Solid Foundations Therapy? _____**

6.**Insurance Information** *(if applicable)*

Insurance Company: _____

ID Number: _____ Group Number: _____

Policy Holder's Name:

_____

Last First MI

Relationship to Client: Self Spouse Parent

Policy Holder's Date of Birth: _____ Policy Holder's Social Security: _____

Address of Insured (If different from client's):

_____

Policy Holder's Employer: _____

Business Phone: _____ May we leave a message? No Yes

I am choosing not to use my insurance: Initial here _____ _____

I,*(Name)*_____ *(Date)* _____ give my consent for ***Solid Foundations Therapy, Inc*** to exchange information with my insurance company for purposes of authorization, billing, and reimbursement. I understand that I am ultimately financially responsible for my balance.

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Consent for Treatment

Services

Solid Foundations Therapy, Inc provides outpatient counseling services to individuals, couples, families.We **DO NOT** offer crisis or emergency services as our therapists are not available outside of their regular business hours. If you feel you are in a crisis you are advised to go to your closest hospital emergency room or call 911. While our therapists are available by phone we cannot guarantee that you would receive a timely response back from your therapist during a crisis.

Initials:_____

Confidentiality

The topics discussed in session, in paperwork, emails or phone calls will not be shared with anyone unless you have given us written permission to do so. If you wish to have information shared with another party, your will be asked to sign a *Release of Information* form to do so. There are three exceptions to this policy as mandated by law:

1. Child or elder abuse is disclosed
2. Believable threat that client will attempt to harm self
3. Believable threat that client will attempt to harm others

Initials: _____

Financial Policy Agreement

Payment in full is due at the end of each session unless a prior arrangement has been arranged between yourself and your assigned Solid Foundations therapy, inc therapist. SFT accepts checks, cash and credit card (VISA, MasterCard and Discover only). You are responsible for all charges for professional services rendered on behalf of the identified client. Including any delinquent billing, attorney fees or court costs associated with the use of outside agencies required for collection of your account.

Fees

*Intake Session $155
*Individual/ Couple Session $140
*Discernment Counselling Intake (2 hrs) $300
*Discernment Counselling Sessions $140
*Cancellation less than 24 hours or failed to show max amount $155
*Returned check / chargeback fee $50.00
*Court Involvement$250 /hour
*Delinquent billing fee $50.00

*Printing of file: $26.58 per request, $1/ pages 1-25, $.66/ pages 25-0, $.33/ pages 51 on

We reserve the right to raise fees on a yearly basis a maximum of 3%. Any fee raises will take effect in January and you will be notified of any changes in November of the previous year.

Clients are required to have a current credit card on file at SFT. Any fees associated with checks returned to Solid Foundations Therapy, Inc by your bank for insufficient funds will be billed to the client and an alternate method of payment will be required.

Statements / bills will be provided monthly by your therapist. Unless requested otherwise, statements will be sent via an encrypted email. **Your Login in is your last name and temporary password is therapy1.** Questions about bills should be directed to your therapist. Balances are due at the 1ist of the month unless other arrangements are made. If a bill is not paid after the second statement due date Solid Foundations Therapy, Inc has the right to run the Credit card on file for the unpaid balance.

Unpaid balances may be referred to an outside agency for further attempts to collect. Accounts referred outside Solid Foundations Therapy, Inc. are assessed a fee. Client understands that Solid Foundations Therapy, Inc. will be required to provide clients information to the outside billing party. If a client disputes a credit card charge Solid Foundations Therapy, Inc. reserves the right to contest it with our company which may result in Solid Foundations Therapy, Inc. being required to provide the clients information to the credit card company. Solid Foundations Therapy, Inc. will do everything possible to preserve the confidentiality of the client. We also encourage you to address any concerns about charges with your therapist first.

Initials: _____

Cancellations, Failed appointments, Rescheduling

Please understand that when you make an appointment, we set aside that date and time specifically for you. we adjust our schedules and other clients times accordingly. It is important to keep your weekly scheduled appointment times to ensure quality therapy and progress. Solid Foundations Therapy, Inc strongly discourages clients missing weeks of therapy as this undermines the therapy process and encourages clients to reschedule within the same week if a schedule conflict does come up. If you do need to cancel or reschedule an appointment please call at least 24 hours before your appointment. **Cancellations with less than 24 hours notice or failed appointments**, will result in the **full session fee** being charged to your account. This will appear as LCFA on your statement. Unless other arrangements are made your credit card will be charged the late cancellation or failed appointment fee on the day that your appointment was originally scheduled for.

Initials: _____

Insurance

Third-Party Payors : Solid Foundations Therapy agrees to file insurance or managed care claims on behalf of the client one time for each date of service. However, filing does not release client from responsibility for payment. Claims not paid within (60) days of filing will become the responsibility of the client. If payment from the third-party payor is received after the client has paid the balance, the client will be reimbursed. By choosing to using insurance you acknowledge that you have been made aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments that you receive. you authorize the release of necessary information to your insurance company or EAP so that Solid Foundations Therapy, Inc may pursue payment for services rendered to you.

Copayments/ CoInsurance **:** Most third-party payers require a copayment or coinsurance fee from the client. This fee is due at the time of service. Co-payments are initially quoted from your insurance company and may not be accurate. Solid Foundations Therapy will not be held responsible for inaccurate quotes from the insurance companies. Accurate co-pays may not be known until claims are returned. Clients are responsible to pay any additional co-pay costs if indicated at that time.Clients using Employee Assistance (EAP) services must supply the Employee Assistance Program managing company, authorization number and contact information at the time of the initial session.

Deductible: Clients will be charged their deductible when applicable. This amount may be unknown until the first claim is processed. Clients will be charged at that time.

Out of Network Insurance: If you are using an insurance that Solid Foundations Therapy is not in network with you will be responsible for paying the full fee of the session at the time of service. You will be reimbursed directly by your insurance company in accordance to your benefits.

Using insurance: Individual, couple and family therapy can only be covered if they meet **medical necessity criteria**. In order to be able to utilize your insurance at least one of the people participating in therapy must qualify for and be given a **mental health diagnosis**. Insurance companies may request your complete records, updates on treatment or information on your treatment. By using your insurance you provide Solid Foundations Therapy with permission to respond to insurance companies requests for any of your treatment information. Please see our website for more details or discuss the pros and cons with your therapist.. Please note that if you **DO NOT** qualify for a mental health diagnosis we can not submit to your insurance as they will not cover sessions without a mental health diagnosis.

Initials: _____

Newsletter

Solid Foundations Therapy send out a newsletter on a bi monthly basis. By providing us with your email address you are giving us permission to add your name to the mailing list. You my unsubscribe at any time. If you wish to not be added please inform your therapist during your first session.

Initials:_____

Feedback forms

We send out feedback forms via email every 6 months to current clients and clients who were seen during that time frame. The from comes from the practice owner (Irene@solidfoundationstherapy.com) and feedback is kept confidential. While you are not required to fill out the form we do encourage you to do so as it helps us maintain the highest stand of care and make changes when appropriate. Access to the forms can also be found on our website if you ever wish to provide feedback. If you wish to not receive a feedback from via email please let your therapist know.

Initials:_____

Electronic Communication

There are times when we may communicate by phone,text, email. Clients have the right to determine which type of communication tools they would like to utilize or refuse. While we will do our best to keep all communication private, please, be aware that electronic communication is not completely secure. Thus, you agree to not hold Solid Foundations Therapy, Inc responsible for any information that may be compromised due to the usage of phone, text or email. We encourage you to communicate with us via our Hipaa Secure portal if necessary.

Initials: _____

Social Media

Use of social media in the context of our counseling relationship presents certain risks to your privacy. These risks include (but are not limited to):Exposing our counselor-client relationship to others, Subjecting private conversations to the public if either of our social media profiles are hacked, Causing you to feel our relationship has become more personal than you are comfortable with. Because of these risks to you, none of the therapists at Solid Foundations Therapy will accept friend requests from clients on social media, follow you on your social media or respond to messages via social media. If you send a friend request, It will be ignored.
You are free to "follow" Solid foundations therapy on facebook (but are not required to do so) as anyone can follow the practice and it doesn't identify you as a client. If you chose to comment on a post, please do so without exposing yourself as a client.

Initials: _____

I Have read and understood all of the above information

_____ _____

Client Signature (if under 12, Parent/Guardian Signature) Date

_____ _____

Client Signature (if under 12, Parent/Guardian Signature) Date

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CREDIT CARD FORM

All clients are required to have a credit card on file with Solid Foundations Therapy, Inc in order to receive services.

Sessions that are cancelled in less than 24 hours or a no show to a scheduled appointment are billed in the same week to the credit card.

If I have an unpaid balance this card will be charged ONLY after the due date on the second notice that has been sent out for the balance owed has passed.

The card on file (either the one listed below or any other card that you provide to your therapist at any point during or after your treatment) is a card that can be used for your weekly charges (deductibles, co-pays, coinsurance or arranged fees) if you choose to pay by credit card.

By signing you acknowledge that you understand the above information.

_____ _____

Signature to acknowledge Date

Credit Card Information:

Type of Card: Visa MasterCard Discover

Card Holders Name:_____

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Billing Address:_____

_____

Cardholder's Phone Number _____

Cardholder's Signature Date

_____ _____

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NOTICE OF PRIVACY PRACTICES
FOR
Solid Foundations Therapy, Inc

I have received the notice regarding my Personal Health Information use and disclosures. I have reviewed the Medical Records Privacy Act Notice for Solid Foundations Therapy, Inc. in its entirety and have been offered a copy of this document.

PLEASE NOTE: In order to avoid confusion or misunderstanding, we ask that if you wish to exercise any of the rights enumerated in the Privacy Policy, that you put your request in writing and deliver or send the writing to us. If you wish to learn more detailed information about any of the above rights, or their limitations, please let me know. We are willing to discuss any of these matters with you.

Date: _____

Name:_____Signature:_____

Name:_____Signature:_____

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Consent to Treatment: Practicum Intern Release

Your treatment will be conducted by one of the masters or doctoral level interns at Solid Foundations Therapy Inc. Very much like medical students, clinical interns must practice for a number of years under the close supervision of experienced professionals before they are fully licensed. A system of supervision ensures that therapists receive an academic education as well as proving to licensed professionals that they are able to provide therapy services in a competent, sensitive, and ethical manner.

Solid Foundations Therapy, inc selects its masters and doctoral level interns with great care. They are carefully screened, and we are confident of the level of service they are able to provide. Interns are supervised on a weekly basis by a senior clinical therapist on staff with Solid Foundations Therapy, Inc. They also receive feedback on a weekly basis from a mentor in their academic program. To facilitate supervision, your therapist will often audiotape your session.

Any information that your therapist shares with a supervisor is covered by strict laws of confidentiality. Supervisors are not allowed to share any identifying information about you with colleagues.

The standard Solid Foundations Therapy, Inc hourly rate is reduced from $155 (intake)/ $140 (all other sessions) to $65 (intake)/ $50(all other sessions). **Clients who choose to work with an intern can not combine this reduced rate with the use of insurance**. All other policies remain the same.

Qualification for this reduced rate is based on income. To prove that your entire household makes less than 85 thousand per year you must provide a copy of a current W2 and a copy of your most recent paycheck stubs.

Your signature below indicates that you have read the above information, understand it and that you consent to receive treatment from a therapist who is under supervision.

Signature _____ Date_____

Signature _____ Date_____

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Consent for Video/ Audio Recording

To ensure the training/growth and quality of our masters level interns at Solid Foundations Therapy, inc; interns will at times request permission to tape sessions. The purpose of recording sessions is to allow therapists and their supervisors to review the sessions and to work to enhance treatment as well as providing therapists with opportunities for professional development.

The content of recorded sessions is protected by confidentiality statutes and recordings will be retained in protected area. Access to the tapes will be limited to therapists and their supervisory team. No one else will have access to the tapes without express written permission of all parties on the tapes. Recordings will be destroyed within twelve months of the time of recording.

1/we hereby consent to allow the therapist intern at Solid Foundations Therapy to make audio and/or video recordings of my/our therapy sessions. This consent will become effective on _____ and will remain in effect until the end of treatment or until _____, Whichever comes first.

I/we have a right to inspect the recording(s) and/or to require that the recordings(s) be destroyed. This request will be honored within one week of notifying the practice in writing. I/we may revoke this consent in writing at any time.

I Have read and understood all of the above information, By signing my name I provide consent.

_____

Client Name

_____ _____

Client Signature (if under 12, Parent/Guardian Signature) Date

_____

Client Name

_____ _____

Client Signature (if under 12, Parent/Guardian Signature) Date