Kerry J DeVries Inc
1580 N Northwest Highway
Park Ridge IL 60068
224 707-0847

General Office Policies and Informed consent

Welcome

Confidentiality and HIPAA

The laws of the State of Illinois require that most issues discussed during the course of therapy with a psychotherapist are confidential. These laws permit you to waive the privilege of confidentiality by signing a release of information form. **However, the release of confidential materials is required in situations of suspected child abuse, of potential harm to oneself or others. And in instances where the court may subpoena records of testimony.** During therapy, you may always request that some information be discussed with another person (i.e. your physician, spouse/partner, children, parents) 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, you will be asked for your written permission to do so. Please read the Health insurance Portability and Accountability Act HIPAA, a federal law offering greater protection for your personal health information, Signing this form will indicate that you understand your HIPAA rights

Appointments

Therapy appointments are typically on a weekly or bi-weekly basis. Monthly appointments are sometime appropriate. Additional sessions can be arranged on an "as needed basis". A therapy hour is 50 minutes in duration and may be referred to as a clinical hour. If you are late for your appointment, it is typically necessary to stop at the normal time.

Cancellations

Scheduled appointments are an important aspect of your services. Your appointment time is reserved for you. If your appointment needs to be cancelled or rescheduled, it is very important to contact me as soon as possible. **It is required that you give advanced notice of cancellation at least 24 hours before your scheduled appointment. The normal session fee will be charged for any late cancellation or missed appointments. Initial** _____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 or for the therapist.

Telephone calls and Emergencies

You may contact me via phone or email between sessions if needed. If there is an emergency (defined as life threatening situation) go to your nearest emergency room or dial 911. No fees are charged for phone calls regarding appointments and similar matters nor are fees charged for calls requiring a few minutes; however**, a pro-rated charge will be made for psychotherapy or psychotherapeutic consultations conducted over the phone that require more than 5-10 minutes.** This is billed at the same rate as private face to face counseling.

Fees

You will be billed for all time spent on you or on your behalf, such as therapist time spent preparing reports, reading letters and documents, consultations, travel time for out of office services and extended telephone calls or emails. Payment is requested at time of service by cash or check.

Insurance Coverage

Payment is due at time of service. If you maintain health insurance, part of your therapy expenses may be reimbursed to you. We will submit to them for your convenience. Be aware that whoever is the insurance policy holder, that person will get a copy of the explanation of benefits. **Remember if fees you expect your insurance company to cover are rejected for any reason, these fees remain the client's responsibility to pay.** Be sure to check who the mental health carrier is on your BCBS plan, as some BCBS plans use other mental health management companies or providers for mental health services, even if the insurance card is a BCBS card. Be sure to check the information and numbers on the back of the card. My

practice manager will arrange a payment plan, at your request, if the need for such arrangements can be established.

Bounced checks
A $20 charge will be assessed for any check given in payment of your account if the check is not honored at the bank because of insufficient funds. This charge will be added to your balance due and shown on your statement.

Delinquent accounts
Late payments will be subject to a penalty fee of 12% per anum. Delinquent accounts may be sent to collections if fee payment obligations are not met in a timely manner, an additional 35% will be added to your account if sent to collections. _____

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

Illinois Law of Required Reporting
If information is revealed in your treatment regarding potential harm to minors or elders or serious threat of harm to yourself or other adults, I am required by law to report this information to the proper authorities.

Caution: Psychotherapy may be upsetting
Be hereby forewarned and cautioned that engaging in psychotherapy may involve experiencing uncomfortable past traumatic events, difficult intense emotions such as depression, anger, grief, confusion or anxiety. It may also result in changes to your life that could be difficult to face.

Ending treatment
You can end therapy at any point you wish. Usually therapy pursues specific goals and you and I will discuss together an appropriate termination process. If you decide that you want to terminate your treatment, but have a scheduled appointment please call me and explain that you wish to take a break or end your therapy. You will be billed and held responsible to pay if you fail to call and cancel that last appointment with 24 hours notification.

Please ask before signing if you have any questions about psychotherapy or my office policies. Your signature indicates that you have read my policies and agree to enter therapy under these conditions. I also authorize my office manager to communicate with your insurance company when necessary to facilitate payment of claims and for appropriate payment to be assigned directly to Kerry DeVries. Remember appointments must be cancelled 24 hours prior to appointment time or you will be charged in full.

Signature(client)_____**Date**_____

Signature (Client/guardian)_____**Date**_____

Signature(witness)_____**Date**_____