AUTISM & ANXIETY
THERAPISTS

1100 Lake Street Suite 210E Oak Park, IL 60301
Email:dlabrose@aatherapists.com
FAX:847.264.4936

Intake Cover Page: CHILD/TEEN

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.

Today's Date: _____

Client Name_____
FIRST NAME MIDDLE LAST NAME DOB

Date of Birth_____ School_____ Grade_____

Parent #1_____
NAME ADDRESS

Email:_____

Parent #2_____
NAME **ADDRESS (if different)**

Email_____

Client Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Parent #1's Phone Number: _____Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Parent #2's Phone Number: _____Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Who is responsible for scheduling appointments? _____

How will client be getting to and from appointments? _____

INSURANCE INFORMATION (Please print clearly)

Member's Name_____ Member's Employer _____

Insurance Carrier_____ Group #_____
Plan_____

Member ID #_____Member's Date of Birth_____

Your relationship to member: SELF CHILD/DEPENDENT

Therapist Assigned: _____

Date & Time of first scheduled appointment_____

Whom can we thank for your referral to Autism & Anxiety Therapists Inc.? _____

Emergency Contact (Name, Phone, & Relationship): _____

_____

Session Fees & Copays: Due at the beginning of each appointment. Payment can be made by cash, check, or credit card. Checks should be made payable to: Autism & Anxiety Therapists Inc.

AUTISM & ANXIETY
THERAPISTS.INC

Autism & Anxiety Therapists Inc.
Dawn La Brose, LCSW
1100 Lake Street Suite 210E Oak Park, IL 60301
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INTAKE COVER PAGE FOR ADULTS

This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.

Today's Date:_____

Client Name_____
FIRST NAME MIDDLE INITIAL LAST NAME DOB

Client Address _____
STREET CITY STATE ZIP CODE

Email_____@_____

Primary Phone Number: _____ Accept texts? Yes No

Do we have permission to leave you a message at this number? Yes No

Secondary Phone Number: _____ Accept texts? Yes No
Do we have permission to leave you a message at this number? Yes No

Patient's Gender_____

Patient's Marital Status: Single Married Widowed Separated Divorced ----------
---------- **INSURANCE**
INFORMATION* (Complete this section only if you wish for us to bill insurance company.)

Member's Name_____ Member's Employer _____

Insurance Carrier_____ Group #_____

Member ID #_____ Member's Date of Birth_____

Patient ID #_____ Patient's Date of Birth_____

Patient relationship to member: SELF SPOUSE CHILD/DEPENDENT

Refer to your insurance card for the following phone numbers: Member Services _____
Behavioral/Mental Health_____ Provider Hotline_____

*Providing this information does not guarantee insurance payment. Client assumes full responsibility for services.

Whom can we thank for your referral to Autism & Anxiety Therapists, Inc.? PERSONAL REFERENCE_____

INTERNET: GOOGLE YAHOO INSURANCE COMPANY _____ OTHER_____

Emergency Contact (Name, Phone, & Relationship): _____

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INSURANCE DECLARATION FORM

(THIS DOCUMENT IS REQUIRED FOR YOUR FILE)

Choosing to bill for counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to pay out-of-pocket and NOT bill through your insurance policy. Clients who so opt are called, Self Pay Clients. Should this be your preference, we (Autism & Anxiety Therapist Inc.) would NOT have the authorization to share your records with your insurance company. The decision you make at the outset of services may be reversed at any time by completing a new form and updating your file.

However, please note that the rates you pay for services as a Self Pay Client may be higher than the rates you would pay if we were an in-network provider with your insurance company. Should you decide at a later date to submit bills to your insurance company, your rates for services would reflect the insurance-rate or Self Pay Client rate AT THE TIME SERVICES WERE PROVIDED ACCORDING TO YOUR CONTRACT WITH Autism & Anxiety Therapists Inc (Here is an example. Let's say you opt to be a Self Pay Client in January and pay for services at $145 per session for 4 weeks. You cannot retroactively change your status from Self Pay Client to Insurance Client for those January dates of service at a later date. If you decide to bill insurance for your February sessions, you would need to complete a new form expressing that preference, and your rates would reflect that change for your February sessions and all subsequent sessions as long as that is your expressed preference.)

O I opt to be designated as a "Self Pay Client" Autism & Anxiety Therapists Inc. I will pay for sessions out-of-pocket with cash, check, or credit card, in accordance with my signed contract for services. I do not authorize Autism & Anxiety Therapists,Inc its agents or employees, to share my private information with my insurance company.

O I would like to seek payment for services through my insurance company. I understand that if Autism & Anxiety Therapists Inc is "in network" with my company, my rates may be discounted according to their contract with my insurance company. I understand that Autism & Anxiety Therapists Inc is "out of network" with my insurance company, I will be responsible for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my plan. I grant this permission to be effective as of the date of my signature and witnessed by a representative Autism & Anxiety Therapists Inc.

_____

CLIENT/ REPRESENTATIVE'S SIGNATURE DATE

_____

Autism & Anxiety Therapists Inc. REPRESENTATIVE'S SIGNATURE DATE

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CREDIT CARD ON FILE

Payments are due at the time of service. Autism & Anxiety Therapists Inc. requires a credit card on file in order to schedule sessions. The credit card on file can be used in order to pay for any copays, co-insurance, deductibles, no shows/late cancellations or out of pocket payments if no other payment method is used at the time of the session or if a late cancellation or no show is incurred (in which case, the credit card on file will be charged our full fee on the day of scheduled session). Clients may also pay by cash or check at each session. Your credit card will be stored in a HIPAA compliant electronic health system and this document will be safely destroy or if you prefer can be saved in a locked file cabinet.

Please check the box and sign below:

☐ Please charge my card for charges in full for sessions at the time of service.

Client Name:		
Cardholder Name:		
Credit Card Number:		
Expiration Date:	Billing Zip Code of Credit Card:	Security Code:
Cardholder's Signature:	Date:	

I understand that by signing above, I am authorizing Autism & Anxiety Therapists Inc. to charge my card in the manner indicated by my initials above. These balances may include co-pays, co-insurance amounts, out of pocket payments, deductibles, no show or late cancel fees.

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CONTRACT, OFFICE POLICIES, AND FINANCIAL AGREEMENT

Please read and sign two copies. Keep one for your records

Autism & Anxiety Therapists Inc. is a business facility where a number of therapists engage in the practice of mental and behavioral health services delivery ("counseling").

Rights and Risks: · Please feel free to ask questions about any aspect of the counseling process. · You need to be willing to discuss what troubles you and be open to change. · You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. The purpose of counseling is to facilitate your process. · If you have been referred by a court or state agency, you have the right to divulge only what you want included in a report.

Confidentiality: · Information shared will be held in confidence with certain limitations. · Information will not be released without your written consent, except for professional consultation if needed and unless required by law. · Your therapist is required by law to disclose information pertaining to suspected child or elder abuse or neglect; inability to care for one's basic needs for food, clothing or shelter; and threatened harm to oneself or others. · The courts may in select cases subpoena counseling records. · It is understood that information regarding treatment and diagnosis will be provided to an insurance company if you opt to bill your insurance company for services. · You may want to discuss further limits or exceptions of confidentiality.

Privacy: By signing this contract, I acknowledge receipt of the separate form Notice of Privacy Practices. I understand Autism & Anxiety Therapists, Inc. utilizes a paper/file management system to maintain my records. I understand that my file is stored in a locked cabinet at the facility. I understand that any counseling session in which I participate with co-therapists is for the purpose of improving my care, and not an invasion of my rights of privacy.

Minors: If you are under 12 years of age, please be aware that the law may provide your parents the right to examine your treatment records. If you are between the ages of 12 and 18, the law may provide your parents the right to examine your treatment records if after being informed of your parents' request to examine your records, you do not object or your therapist does not find that there are compelling reasons for denying the access to the records. Notwithstanding the above, your parents are always entitled to the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Before giving them any information, your therapist will discuss the matter with you, if possible, and do their best to handle any objections you may have with what is prepared to discus

Court Related Services: We do not provide or perform evaluations for custody, visitation or other forensic matters. Therefore, it is understood and agreed that we cannot and will not provide any testimony or reports regarding issues of custody, visitation or fitness of a parent in any legal matters or administrative proceedings. If we are contacted by an attorney regarding your treatment (either at your behest or related to a legal matter you are involved in) please note the following:

• We charge a $1500 retainer prior to any preparation or attendance of legal proceedings.

• We charge $400/hour to prepare for and/or attend any legal proceeding and for all court related services

. • Charges for court related services are not covered by insurance.

• Court related services include: talking with attorneys, preparing documents, traveling to court, depositions and court appearances.

• If the court or attorneys do not pay our fee, you will be charged for the time we spend responding to legal matters

• You will also be charged for any costs we incur responding to attorneys in your case, including but not limited to fees we are charged for legal consultation and representation by our attorneys.

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Appointments: · All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is **53 minutes**. · Late cancellations (less than 48 hours before) will result in **a $145.00 session fee. No-show appointments are charged $145.00 to the credit card on file**. If your appointment is cancelled or missed, contact your therapist for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

Emergencies: The best phone number for you to call is the direct phone number of your therapist. If your call goes to voice mail, please leave a message. In a crisis situation, call 911 or go immediately to your local emergency room.

Social Media Policy: In order to maintain your confidentiality and our respective privacy, we do not interact with current or former clients on social networking websites. We do not accept friend or contact requests from current of former clients on any social networking sites including Twitter, Facebook, LinkedIn, etc. We will not respond to friend requests or messages through these sites. We will not solicit testimonials, ratings or grades from clients on websites or through any means. We will not respond to testimonials, ratings or grades on websites, whether positive or negative, in order to maintain your confidentiality. Our hope is that you will bring concerns about our work together to the therapy session so we can address concerns directly. Please do not contact us through text messages or emails regarding clinical issues. These are not a secure communications, and there is possibility that we will not get the message in a timely manner, or that communication will be interpreted in an unclear manner. If you need to contact your therapist between sessions, please call. Text messages and emails are only to be used for scheduling, changing or canceling appointments.

Fees: · Payments and co-payments for services are required at the time services are rendered. · Your health insurance may help you recover some of your counseling costs. Verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals.· Regardless of your intention to use insurance, the "Insurance Declaration Form" MUST be on file before services can commence. · By signing this contract, you acknowledge responsibility for payment per hour for any demand on the therapist's time that occurs under your direction and/or on your behalf. This includes time demands that result from involvement in any legal proceeding. The fees are detailed on page 2.

"Self Pay Clients" as defined in our Insurance Declaration Form are expected to pay their fees at the time services are rendered. Our office will provide an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account, either in paper copy or via email when we are granted permission to do so. This office will not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. Clients and parents/guardians of minor clients are responsible for payment (and insurance claims) on their accounts. Accounts become delinquent after thirty (30) days. **Delinquent accounts may be turned over for collection at the responsible party's expense. CLIENT/RESPONSIBLE PARTY ACKNOWLEDGEMENT AND ACCEPTANCE OF TERMS:** Any change in my financial or insurance situation I will discuss with my therapist. I have read, understand, and agree to the above policies and the fee schedule on Page 2 of this contract. I have discussed these policies with my therapist if desired and all questions are answered to my satisfaction. I have been offered a copy of these policies and understand a copy is available on the practice website. I hereby authorize Autism & Anxiety Therapists, Inc. and my therapist to abide by my expressed preferences on the Insurance Declaration Form I submitted with this contract**. I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that Co-pays and Deductibles are not negotiable.**

Consent to Treatment and Fee: I hereby agree to full responsibility for all expenses incurred by me and/or on account of this client and hereby assign Autism & Anxiety Therapists Inc. and all Insurance benefits due to me to the full extent of my financial obligation to Autism & Anxiety Therapists Inc. I have read and/or received a copy of Notice of Privacy Practices Policy. A completed Insurance Declaration Form is required for my file.

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FEE SCHEDULE I acknowledge and understand the fee schedule, detailed in the table below. I understand that the STANDARD portion of the fee schedule may be submitted to my insurance company for payment if I authorize Autism & Anxiety Therapists Inc. to do so on my behalf. I understand and accept that I am responsible for copays and deductible amounts. **In the event that I cancel an appointment within 48-hours or fail to attend a scheduled appointment (NO SHOW), I hereby authorize Autism & Anxiety Therapists, Inc.to charge to my credit card the on file the appropriate fee.**

CONTRACT, OFFICE POLICIES, AND FINANCIAL AGREEMENT

I understand that that the "ADDITIONAL" portion of the fee schedule is not billable to insurance and will not be paid for by a third party. Any "ADDITIONAL" fees incurred by me or by my dependent child are my sole responsibility.

STANDARD FEES	0-30 minutes	31-52 minutes	53-60 minutes	Fee
Initial Intake Assessment/Interview				180 per unit hr.
Individual Counseling	120	135	145	
Family Counseling			170	

ADDITIONAL FEES (to be paid by the undersigned)	
Cancel less than 48 hours	$145
NO SHOW	$145
Phone Calls,past 5 minutes is $2.00 a minute	$2.00 a minute
Consultation with outside agencies/schools	$150 (up to 1 hour)
Depositions, subpoenas, legal and/or court proceedings	$400 (up to 1 hour)
Paperwork/Form completion/Letters	$145hr

Statement of Understanding: Your signature below assumes you have read (pages 1-3) of the **CONTRACT, OFFICE POLICIES, AND FINANCIAL AGREEMENT** , I understand, and agree to abide by the above. It also assumes that you give your consent for us to provide you with psychotherapeutic services.

_____ _____ _____
Client's Printed Name Client's Signature (age 12 and older) Date:

_____ _____ _____
Parent's Printed Name (client is minor) Parent's Signature Date:

Go Paperless! By providing your email address, you authorize Autism & Anxiety Therapists Inc.to issue your invoices and statements via email. You may withdraw your consent at any time by providing a request in writing.

_____@_____ _____ Email address (PLEASE PRINT CLEARLY!) Signature