Birch River Wellness, PC

Pamela Bell, LCSW 4633 N. Western Ave., #201, Chicago, IL 60625

Client Service Agreement

Welcome to Birch River Wellness, the therapy practice of Pamela Bell, LCSW. Please read the following information regarding the services that you are beginning today. Please notify your therapist if you have any questions or concerns about this information or anything related to receiving services.

Treatment Guidelines

Length of Sessions: Therapy sessions are scheduled for 50 minutes. Appointments are usually once per week at a regularly scheduled time, unless other arrangements better meet your needs.

Phone/E-mail Policy: Clients may contact their therapist via phone and e-mail. The therapist will not charge for return calls or e-mails, provided that it does not require over 10 minutes of the clinician's time. The client will be charged for any time exceeding 10 minutes, at a rate of $40 per 15 minute increment. Each client is responsible for this fee, as insurance will not be charged.

Cancellation Policy: Your therapy time is reserved exclusively for you. If you are unable to attend your scheduled appointment, please call or text (312) 203-3405 to cancel your appointment no less than 24 hours prior to the reserved time. Voice mails and texts may be left 7 days a week, 24 hours a day. If you do not cancel with 24 hours notice, you will be charged $100.00 for the appointment. The insurance provider cannot be billed in this circumstance. Please note that the cancellation fee still applies even if we are able to find an alternative time to reschedule your appointment that same week.

Confidentiality: All material discussed in sessions and all written records of services are confidential and cannot be released to another person or agency without client approval. However, clients using insurance may be required to release additional information, which varies from plan to plan. Clients may also consult the Notice of Privacy Practices form. Additionally, the therapist is legally obligated to break confidentiality in the following cases:

1) The client presents a clear and imminent risk to his/herself or others.
2) The client discloses or there is suspicion of the neglect, physical abuse, sexual abuse or financial exploitation of minors, a dependent adult, or the elderly.
3) There is a court-ordered valid subpoena.

Client Emergencies: The therapist is not available on a crisis or emergency basis. In the advent of an emergency that threatens the health or well-being of yourself or someone else and requires immediate assistance, you are to call 911 or go to the nearest hospital emergency room.

Professional Consultation: In order to ensure proper treatment, the therapist may seek outside consultation with other professionals in order to discuss a case. In order to protect confidentiality, no identifying information will be provided to the consultants, unless the client provides permission.

Treatment Disclaimer: The goal of the therapy process is to help resolve personal difficulties. The therapist will attempt to help clients to feel comfortable during sessions and assist them towards meeting goals. However, clients should be aware that psychotherapy may periodically produce heightened feelings of emotional distress and discomfort. If this occurs, clients should notify their therapist in order that the symptoms are properly addressed.

Discontinuation of Service: Usually therapy is ended when the client's goals have been achieved. Regular attendance in therapy helps produce maximum benefits but clients are free to discontinue treatment at any time. If you decide to do so, please notify the therapist at least two weeks in advance so that effective planning for continued care can be implemented.

Fee and Payment Guidelines

Cost: Individual sessions are billed at a rate of $175 for the first session and after that at $160 per session.

Responsibility: Clients are responsible for all treatment costs. Clients using insurance will also be responsible for all non-reimbursed services. These non-reimbursed costs may include deductibles, co-payments, claim rejections, missed sessions and non-covered procedures.

Insurance Coverage: Prior to treatment, clients are strongly encouraged to contact their carriers to determine their coverage and benefit information. The therapist is not responsible for finding this information.

Out-of-Network Reimbursement: If the therapist is not part of your insurance provider's network, you may request out-of-network reimbursement from your insurer for fees you paid. The therapist will provide you with the necessary receipts and documentation to simplify this process. If your insurance provider denies payment, you do not have insurance coverage, or you choose not to use such coverage, you will be responsible for all fees for services provided.

Payment Method: The therapist accepts cash, personal checks and payment via the Zelle app for all fees, deductibles, co-pays and co-insurance amounts owed.

Timely Payment: Payment is due at the beginning of each session. In order to make the most efficient use of the session, clients are encouraged to attend to payments owed before the session starts.

Returned Checks: Clients will be charged a $25 fee for the cost associated with returned checks.

Please fill out the billing authorization below if you are a Blue Cross Blue Shield PPO member.

Insurance Billing Authorization

Client Name:			**DOB:**
Street Address:	**City:**	**State:**	**Zip:**
Home phone:	**Work phone:**		**Cell phone:**
Employer:			

Policy Holder's Name (if other than client):			
Relationship to Client:			**DOB:**
Street Address:	**City:**	**State:**	**Zip:**
Home phone:	**Work phone:**		**Cell phone:**
Employer:			

Insurance Provider:		
Group #:	**Member ID:**	**Provider's Phone:**

Authorization of Non-Secure Communication Means

Please initial all that apply:

I authorize Pamela Bell to send text message appointment reminders_____

I authorize Pamela Bell to communicate via text re: scheduling appointments, information related to billing and payment, and in response to texts from me_____

I authorize Pamela Bell to send emails and attachments (such as reading assignments, articles etc.) using her (non-encrypted) email address pam@birchriverwellness.com _____

I authorize Pamela Bell to leave voicemail messages on my mobile phone_____

Client Consent to Terms of Agreement

I, the undersigned understand and accept the Client Information & Service Agreement and request services from Birch River Wellness, PC/Pamela Bell, LCSW.

I give Birch River Wellness, PC/Pamela J. Bell, LCSW, permission to release any information obtained during treatment that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or myself. I understand that I am responsible for all charges, regardless of insurance coverage. Assignment of benefits: I hereby assign medical benefits, to be paid to the therapist above. A photocopy of this assignment is to be considered as good as the original.

_____ _____

Signature of Client Date

_____

Print Name