North Shore Therapy PLLC
Practice Policies and Procedures

CKroe@NorthShoreTherapy.org | 312-509-0785

Welcome to North Shore Therapy PLLC! This document describes our policies and procedures. We require all clients to review and agree to these policies before beginning to receive our services. Please read this document carefully.

Please note: We may update these policies and procedures and provide you with a copy. You acknowledge and agree to be bound by the updates.

Therapy Services

We understand that therapy is sacred work involving healing, growing, and actively cultivating positive life changes. We work with clients of all ages and provide many services to clients facing a wide variety of symptoms, including acute and post-traumatic stress, depression, ADHD, life transition stress, bipolar disorders, grief and loss, divorce, anger management, and other mental health matters. We use many treatments (called "modalities") when working with clients, including Dialectical Behavioral Therapy (DBT) and Eye Movement Desensitization Reprocessing (EMDR).

Information About You

"You" refers to the client.

Name: _____ Date of Birth: _____

Sex: _____ Pronoun Preference: _____ Relationship Status: _____

Mailing Address: _____

Email: _____

Cell Phone: _____ Home Phone:_____

Email: _____ With whom do you live? _____

Your Care Team

Please provide us with information about the other professionals who are involved in your healthcare. This does not mean we will contact them. It just allows us to plan your care.

Primary Care Provider | Check here if we may contact this person. ☐

Name: _____Date of Last Visit: _____

Practice: _____ Address: _____

Phone: _____ Email: _____

Emergency Contact Information

Name: _____ Email: _____

Relationship to You: _____ Phone: _____

Social Media Policy

We will not accept friend or contact requests from current or former clients on any social networking site. Adding clients or contacts on social networking sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship.

Privacy and Security and Medical Records

Notice of Privacy Practices. We comply with all state and federal medical privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). These laws require us to protect the confidentiality and privacy of your health records and personal information.

We have implemented privacy policies and procedures to ensure our compliance with these requirements. This information is summarized on our Notice of Privacy Practices, which is included at the end of this document. It is also available on our website and upon request. Please ask if you have questions about how we protect your privacy. Your signature at the end of this document signifies your acknowledgment that you have been offered and have accepted a copy of our Notice of Privacy Practices.

Medical Records. We maintain records of our services to you. If you want a copy of your records, or if you want us to send your records to another provider, please ask us for a medical records request form.

Please note that, in some instances, we may charge reasonable and cost-based copying, postage, shipping, scanning, or digital storage device fees.

Communications, Cancellations, and Payment Policies

Communications. By providing the above contact information, or by initiating communication with us by e-mail or text message, you authorize us to call, leave voicemails, and send text messages using that information. We will use this information for non-marketing purposes, including appointment reminders, billing and invoicing updates, and treatment questions.

You further understand and agree that communicating with us by unencrypted e-mails and text messages may not be secure. This also means that your protected health information (called PHI) may be transmitted in this way, including information about your appointments, diagnosis, progress, and other individually identifiable information.

If you choose to communicate via text or e-mail, please limit the content to general information (such as scheduling or asking for a time to talk via phone). Please be aware of privacy risks when using electronic means of communication.

Cancellations. We have reserved your appointment specifically for you. If you need to cancel or reschedule your appointment, please contact us during business hours and at least 24 hours before your scheduled appointment to avoid a cancellation fee of $50.

For Monday appointments, you must cancel by 12:00 p.m. on the previous Friday so we can offer that time to another client. If you cancel without providing the proper notice, or if you fail to show up for a scheduled appointment, you must pay any cancellation charges before making an additional appointment. If you arrive more than 15 minutes after your scheduled appointment time, we may need to reschedule your appointment time, and you may be charged a late cancellation fee for the visit.

Payment. We are in-network providers with BlueCross BlueShield PPO and Medicare insurance.

If we do not accept your insurance, you can pay us at the time of service and submit claims on your own for out-of-network reimbursement. You understand that you are wholly responsible and liable for payment of all charges assessed for professional services rendered.

If you decide to file your own claims for out-of-network reimbursement, your insurance may not cover these services, or it may consider them to be subject to lower out-of-network benefits. We do not guarantee that your insurance will cover our services. Your insurance company will not pay some fees, like cancellation fees, and these fees will be your responsibility to pay.

Credit Card Policy

For your convenience, you can keep a current credit card on file. By providing your credit card information below, you authorize us to charge unpaid balances and fees of any kind to this card. The most common charges include our services and cancellation fees. We will save this credit card information in your file for future charges.

Name on Card: _____ Relation (if not yours): _____

Card Billing Phone: _____ Email: _____

Card Billing Address: _____

Street Address City State Zip

Type of Card: ❒ Visa ❒ Mastercard ❒ AMEX ❒ Discover | ❒ Other: _____

Card Number: _____

Exp. Date: _____ Security Code: _____

If you pay by check and that check is returned to us for any reason, you agree that the following will be charged to your card: your entire balance due, any returned check fees charged to us, and a $50 fee to cover our billing services management of the situation. If you do not provide a valid credit card, any unpaid balances will be sent to collections. Collection agencies may impose additional fees on your bill.

By signing below, the cardholder authorizes the above credit card to be charged for agreed purchases or services, including cancellation or returned check charges, and to be saved to our file under this policy.

_____ _____

Cardholder Signature **Date**

Mandatory Reporting

Child and Elder Abuse Reporting. Illinois law requires us to report to the Department of Children and Family Service if we have reasonable cause to believe that a child who is known to us in our professional capacity may be abused or neglected. It is our policy to notify you first. Illinois law also requires us to report any abuse of elders or vulnerable adults to the Department of Health and Human Services. This may include physical, sexual, financial, or psychological abuse, neglect, or exploitation.

Firearms Reporting. If we determine that you pose a clear and present danger to yourself or others, or if we determine that you are developmentally disabled, we are required to report that information to the Illinois Department of Human Services (DHS). DHS will redisclose this information only if it concerns the issuance of a license under the Illinois Firearm Owners' Identification Act (FOID).

Duty to Warn. If you tell us that you intend to cause serious mental or physical harm to a specifically identifiable victim, including yourself, and we determine that you present a clear and imminent risk of harm, Illinois law requires that we warn the potential victim and the authorities (e.g., police). This means that we may disclose otherwise confidential information for this purpose.

Informed Consent

Client name _____ **Date of first visit** _____

You will complete this form with your therapist at your first appointment. You may review it in advance, but you will sign it in-person (virtually)

Before we may provide therapy services to you, the law requires that we obtain your informed consent. You can only provide us with your informed consent after we have discussed your proposed services, the potential risks of those services, the potential benefits of those services, and information about any potential alternative services. Please tell us immediately if you experience any health changes or ever become uncomfortable during therapy services.

I, the undersigned client, acknowledge that North Shore Therapy PLLC, its owners, agents, or employees, will take part in therapy services with me.

I acknowledge that the ideas, goals, and methods of the therapy services have been explained to me, and my therapist will use methods that are appropriate for me. I further acknowledge that periodically during treatment, my progress will be evaluated, which may also change my treatment goals.

Agreement and Acknowledgment

I acknowledge that:

- The therapy services and its risks, benefits, side effects, and alternatives have been explained;
- The therapy services may not have the result that I expect, and I have been informed as to other possible treatments that may provide me a benefit;
- I have not been given any guarantees about the result of any treatment;
- Neither party has consented to record therapy sessions, and I agree that I will not record any sessions;
- I have had ample opportunity and time to discuss my concerns, and all my questions have been answered to my satisfaction.

By signing below, I acknowledge that I am competent, understand this policy, and have been provided material information regarding the proposed care, treatment, service, intervention, or procedure, and the anticipated risks, benefits, side effects, and alternatives, as well as the risks of non-treatment. Thus, I hereby provide my informed consent to receive the Treatment as described in this document.

Furthermore, as described above, my therapist has explained the therapy services that I will receive, as well as its material risks and benefits. I further acknowledge and agree to the following statements:

- I have read and understand this entire document and am bound by this document.
- I have truthfully provided the information requested.
- I have been offered and accepted our Notice of Privacy Practices.
- I authorize the use of my health information for the purpose of these services.

My therapist has offered me ample time and opportunity to discuss my concerns, and all my questions have been answered to my satisfaction.

This document may be electronically signed. Electronic signatures on this agreement are the same as handwritten signatures for validity, enforceability, and admissibility purposes.

Print Client Name	**Date**

Client Signature