INFORMED CONSENT

*Thank you choosing **Innovative Behavioral Health.** Today's appointment will take approximately 45 – 50 minutes. I realize that starting coaching/therapy is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.*

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims/verify treatment or information necessary to collect payment, b) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared, and e) if you provide information that informs me that you are in danger of harming yourself or others f) and as outlined in the HIPAA Notice of Privacy Practices. I only maintain clinical records and do not keep psychotherapy notes. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community for those services. **Innovative Behavioral Health, PC** will follow those emergency services with standard therapy and support to the client or the client's family.*

Signature(s)_________________________________Date:___________

FINANCIAL/INSURANCE ISSUES: *In most cases, I ask that you pay your full fee at each session. I will provide the necessary paperwork for you to submit to your insurance company for reimbursement. In some cases, the insurance company will pay me directly, and as long as that has been pre-arranged with your insurance provider, I will only ask for your co-pay portion for that session.*
If you need to cancel or reschedule an appointment, please give 24 hours notice, otherwise a charge of $35.00 will be applied. I sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.
In the event that my account becomes past due and is turned over to collection, I will be responsible for all cost of collections, including collection agency expenses and fees not to exceed 50%, and all cost to file suit including attorney fees and court costs.

Signature(s)_________________________________Date:___________

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that I have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.*

____You may inform my physician(s) **_____I decline to inform my physician**

PHYSICIAN NAME:____
CLINIC:____
ADDRESS:____
PHONE:_____________________________________
There is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Signature(s)_________________________________Date:___________

Oswego, IL 60543 • Naperville, IL 60540
Phone (630) 913-7045 • Fax (630) 551-2213

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read and received a copy of the **Notice of Privacy Practices** and **Client Rights document**.*

***Signature(s)*___________________________________*Date:*____________**

	Check all that apply		Phone Number
	Yes	No	
May I contact you at home?			
May I contact you at work?			
May I contact you by cell phone?			

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS UNDER 18 YEARS OF AGE:

I/We consent that ____ maybe treated as a client by Innovative Behavioral Health, PC
***Signature(s)*___________________________________*Date:*____________**

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