WELCOME

You will find your process in therapy with us to be a confrontive, supportive and encouraging growth producing experience. If you are active in your treatment you will develop methods and skills to solve your problems and develop a strong sense of inner personal power. That power you feel comes from removing the emotional blocks and barriers that are integral parts of your life experience. Your therapy will enable you to lead a more productive and fulfilling life without these barriers.

Making the first telephone call for your evaluation session is often the most difficult and anxiety producing step for you to take in the growth process. Congratulations for making the first phone call and taking the needed risks to change your life.

Sincerely,

Kalli N. Rimikis-Kerr, MA, LMFT
CITY THERAPY CENTER

NOTICE OF PRIVACY PRACTICES
HIPAA Notice Form – Client Copy *PLEASE KEEP THIS SHEET* Effective April 14, 2003

This notice describes how treatment information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

RIGHT TO PRIVACY

Health care providers are required by federal and state law to maintain the privacy of your treatment information. We are also required to give you notice about our privacy practices, our legal duties and your rights concerning your treatment information.

City Therapy Center (CTC) must follow the privacy practices that are described while it is in effect. CTC reserves the right to change our privacy practices and the terms of this notice at any time provided such changes are permitted by applicable law. You may request a copy of the notice at any time from us.

USES AND DISCLOSURE OF TREATMENT INFORMATION

CTC may use information about your health care to provide you with treatment, to arrange payment for services and in conjunction with other health care providers, organization, and other professionals. The information privacy practices in this notice will be followed by any associate involved in your care and any business associate with whom CTC shares health information.

The following categories describe examples of the way CTC uses and discloses treatment information:

FOR TREATMENT: CTC may use and disclose your treatment information with another mental health professional. For example, CTC may provide information to your health plan or other providers to arrange for a referral or consultation.

FOR PAYMENT: CTC may use and disclose your treatment information to obtain payment for services provided, including but not limited to business in connection with billing and collection activities. For example, CTC may contact your insurer to verify benefits and obt ain prior authorization to make sure they will pay for your care.

LEGAL PROCEEDINGS: CTC may disclose information in response to a court or administrative order, subpoena, discovery request or other lawful process under certain circumstances.

CTC may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. CTC may disclose information to the extent necessary to protect your health or safety of the health or safety of others.

CTC will not disclose your treatment information if that disclosure is prohibited or significantly limited by other applicable

law. **YOUR HEALTH INFORMATION RIGHTS**

You have the right to inspect or copy treatment information that may be used to make decisions about your care with limited exceptions. You must submit a written request to CTC.

You have the right to request restrictions on uses and disclosures of your treatment information for the purpose of treatment , payment or healthcare operations. CTC is not required to allow your request. If we do agree with the request, CTC will comply with your request except to the extent that disclosure has already occurred or if you are in the need of emergency treatment and the information is needed to provide the emergency treatment.

You have the right to inspect or copy treatment information that may be used to make decisions about your care with limited exceptions. You must submit a written request to the address listed below.

You have the right to request that CTC amend or make changes to your treatment record. Your request must be in writing and it must explain why the information should be changed.

You have the right to receive a list of instances in which we disclosed information for purposes other than treatment, payment, or those disclosures you have authorized in writing.

You have the right to request that CTC contact you by alternative means or at alternative locations. For instance, you may ask that CTC contact you at work. You must inform CTC in writing that alternative means are required and provide an explanation of how payments will be handled under the alternative means.

QUESTIONS AND COMPLAINTS

If you would like to request information or file a complaint, please send it to: City Therapy Center, 70 West Madison, Suite 650, Chicago, IL 60602. You also have the right to file a complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C., 20201. There will be no retaliation for fi ling a complaint.

PERSONAL INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

CITY: _____ STATE: _____ ZIP: _____

Home Phone: _____ Phone: _____

Email Address: _____ May we contact you via Email? Yes No

Employer: _____

Address: _____

Occupation: _____

Business Phone: _____

How did you learn about this practice?

_____

Person to notify in case of emergency:

Name: _____ Male Female

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

FOR OFFICE USE ONLY:

FIRST SEEN: THERAPIST: CPT CODE: FEE:

CLIENT AGREEMENT

1. Good Faith: I will keep agreements and acknowledge broken agreements. This includes keeping scheduled appointments and participating as fully as I can in therapy sessions.

2. Payment Policy: I agree to pay for each scheduled session at the time of the appointment.

3. Cancellation Rule: I will be charged for all scheduled sessions unless CTC receives a 24 hour notice of cancellation.

4. Insurance Coverage: I understand that I am responsible for dealing with my insurance company, and that I am responsible for my balance.

5. Confidentiality: I understand that all information concerning clients are held confidential and, are released (if required), through procedures consistent with professional ethics and the privacy practices as described in the HIPAA Notice Form.

6. Grievances: I agree to communicate any problems with my therapist as soon as possible.

7. Termination of Therapy: By beginning therapy with CTC, I agree to responsibly conclude my therapy. Once my initial assessment and treatment plan is completed, I will allow three sessions for completing individual and/or group therapy, unless my therapist and I agree otherwise.

Signature: X_____Date: _____

SIGNATURE PAGE

Your signature below indicates that you have received and read the following forms:

- **The HIPAA Notice Form**
- **Client Agreement Form**

Name (please print):

_____

Date: _____

Signature: X:_____

CLIENT PAYMENT AGREEMENT

I, _____ am aware that fees are due at the time of service, unless alternate arrangements have been made with CTC. I am aware that I will be charged if a cancellation is made less than 24 hours in advance except for medical/family emergencies. Therapy in office is charged at the rate of $__ per 50 minute session. Telephonic sessions are billed at the same rate but based on the actual time of the session.

I understand that my individual/group therapy may not be authorized for payment under my health plan. I choose to continue with my therapy even though my insurance may not cover it. I take full responsibility for payment of all fees in connection with the above treatment. Any insurance reimbursement is considered out-of-network.

I will pay a $35 service charge for all checks that are returned as NSF, Account Closed, or Stop Payment. I agree to be responsible for any collections fees or legal costs incurred by CTC if they become necessary to secure payment for services rendered.

Signature:

X_____

Date: _____

AUTHORIZATION FOR CREDIT CARD PAYMENT

I,_____authorize CITY THERAPY CENTER to keep my signature on file and automatically process Visa/Master Card payments for professional services rendered including:

Balance of charges not paid by insurance within 60 days of billing date.

Balance in full upon termination of therapy.

Sessions cancelled with less than 24 hour notice.

_____Check here to have each session charged to your credit card account at the time of visit.

Please Circle: VISA MASTERCARD

Card Account Number:_____

Expiration Date: _____

Authorization Code: _____

Address:_____

_____

Zip Code: _____

Name as it appears on Card:

_____

X_____
Cardholder Signature

X_____
Client Signature