Have Dreams
2020 Dempster Street
Evanston, IL 60202
Phone: (847) 905-0702
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Have Dreams
HELPING AUTISTIC VOICES EMERGE

CONTRACT, OFFICE POLICIES, AND FINANCIAL AGREEMENT

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

Have Dreams 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, experience intense emotions, and/or experience changes in your close relationships. The purpose of counseling is to facilitate your individual process.

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 self 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 Have Dreams utilizes an electronic file management system to maintain my records. I understand that my file is stored in a secure online platform. 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.

Appointments: All sessions are by appointment with your therapist directly. Please arrive on time. The usual length of an appointment is 30, 45, or 60 minutes. **Late cancellations (fewer than 24 hours before) will result in a $25 fee**.
No-show appointments are charged $50 to the credit card on file. If your appointment is canceled 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.

Fees: Payments and co-payments for services are required at the time services are rendered. Your health insurance company 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: I will discuss any change in my financial or insurance situation with my therapist. I have read, understood, 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 Have Dreams 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.

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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 Have Dreams and all Insurance benefits due to me to the full extent of my financial obligation to Have Dreams. I have read and/or received a copy of Notice of Privacy Practices Policy. A completed Insurance Declaration Form is required for my file.

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 Have Dreams 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 24 hours or fail to attend a scheduled appointment (NO SHOW), I hereby authorize Have Dreams to charge to my credit card the appropriate fee.

I understand 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	Flat Fee
Initial Intake Assessment / Interview	__	__	__	$225
Individual Counseling	$105	$135	$195	__
Family Consultation (without client present)	__	__	__	$150
Family Consultation (with client present)	__	__	__	$170
Group Counseling	__	__	__	$50

ADDITIONAL FEES (to be paid by the undersigned)	
Cancel less than 24 hours	$25
No Show Fee	$50
Phone Calls 5-15 minutes	$40
Consultation with outside agencies/schools	$150 (up to 1 hour)
Depositions, subpoenas, legal and/or court proceedings	$300 (up to 1 hour)
Paperwork/form completion/letters	$40

Client(s) Signature(s): _____ Date: _____

Client(s) Signature(s): _____ Date: _____

Go Paperless! By providing your email address, you authorize Have Dreams 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

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