INFORMED CONSENT

Thank you for choosing Lisa M. Berg, LCSW and Associates, LLC. Today's appointment will take approximately 90-120 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. Lisa M. Berg, LCSW has earned a Bachelor of Social Work Degree from Illinois State University and a Masters Degree in Social Work from the University of Illinois at Chicago. She is a Licensed Clinical Social Worker in the State of Illinois. She has over 18 years of clinical experience treating children, adolescents, adults and families dealing with a variety of issues such as depression, anxiety, ADHD, stress management, grief, life and family transitions among other life stressors and mental health issues. Lisa also has expertise in the field of physical and sexual abuse. She utilizes a solution-focused approach while working with each client to enhance their own strengths and supports. Other integrative therapy methods are also used. Lisa's philosophy on the helping relationship, clinical impressions, treatment plan and risks of treatment will be discussed with you today.

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, b) information you and/or you child or children report about physical, sexual abuse or elder 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 d) if you provide information that informs me that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. Please understand I do not provide 24 hour emergency coverage in my practice. When a client or their guardian feels immediate attention is necessary, and they cannot wait for a call back during normal business hours they are to contact the emergency services in the community (911) for those services. Lisa will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s) _____Date:_____

FINANCIAL/INSURANCE ISSUES: As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or fee that is required by your insurance. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $200.00 we will need to ask that you pay for services when rendered and the balance will need to be paid before another session can be scheduled. For clients using their Employee Assistance Program (EAP Benefits) we will submit a claim directly and there is nothing more for you to do. If you decide not to use your insurance you will be private pay client and full payment is required at the time services are rendered. We ask that every client authorize payment of medical benefits directly to: Lisa M. Berg, LCSW & Associates, LLC. Lastly, if you need to cancel or reschedule an appointment, **please give 24 business hours advance notice, otherwise you will be billed a $100.00 no show fee** (Does not

apply for EAP). This will need to be paid in full to schedule all future appointment unless other arrangements have been made with your clinician. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested. A copy of a fee schedule was given to me: If you are using EAP benefits you do not need a fee schedule unless you request one.

Signature(s)_____Date_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we 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 we 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:_____

Signature(s)_____Date_____

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 if requested.

Signature(s)_____Date_____

May we contact you at home? (Circle one) YES NO. May we contact you at work? YES NO? May we contact you by cell phone YES NO. Where may we contact you?_____Ok to leave message YES NO

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by Lisa M. Berg, LCSW. It is understood that children over the age of 12 have confidentiality protected by law. This consent to treat expires at the end of treatment or if revoked in writing.

Signature(s) _____***Date***_____
Client signature

Signature(s) _____***Date***_____
Parent/Guardian