Dr. Arin Davidson-Stevens, PsyD | astevens@prpsych.com | (847) 915- 6078 Ext:#3
210 Skokie Valley Road Suite #12 | Highland Park, Illinois 60035 | www.hppsychservices.com

Client Acknowledgement & Informed Consent

* Please read, fill out, sign and send to astevens@prpsych.com prior to your appointment.

Patient Name:_______________________________________Date of Birth:_________________________________

Parent/Legal Guardian: ____

I hereby authorize the psychological treatment and /or evaluation of myself (or the above-named child) by Highland Park Psychological Services. I have discussed the stated goals of psychological treatment and/or evaluation and I understand that I have the right to ask the therapist/evaluator information regarding diagnosis, goals for treatment, and estimated length of treatment.

Fee Schedule

*We do accept Blue Cross Blue Shield Insurance.

Initial Consultation:	$200
Group Psychotherapy:	$60.00/hour
Report/Letter Writing:	$50 per 15 minutes
Individual/Family Session Fees:	
	20-30’ Session: $100
	40-45’ Session: $150
	50-60’ Session: $180

Fee Agreement

I agree to pay in full all fees for services provided and I understand and agree that I am responsible for any charges not covered by insurance or any other third-party payor.

I hereby request that payment of insurance benefits be made directly to Highland Park Psychological Services. I authorize Highland Park Psychological Services to release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement.

If my insurance policy does not cover the necessary services, or if I do not receive prior authorization as required by my insurance company, or such authorization has not been timely obtained or has been denied by my insurance carrier, I agree that I will be responsible for the entire payment for services and may be billed as a private/ self-pay. Further, I understand that I am responsible for and agree to pay any copayments, deductibles, co-insurance, non-covered services or amounts in excess of my insurance policy’s annual and/or lifetime maximum benefit and understand that any such payment is due at the time of services. I understand if I choose to pay using a credit card there will be an additional 3% charge.

In the event that the client has multiple guarantors, a credit card will be placed on file for each individual guarantor. Highland Park Psychological Services is not responsible for contacting outside guarantors.

Unpaid balances must be paid within two months of being billed. Failure to pay after two months will result in the credit card on file being charged the full balance.

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Cancellations & Missed Appointments

I have been informed of the procedure for reaching Highland Park Psychological Services in the event of an emergency. I also understand the policy regarding cancellations and missed appointments. Unless there is an emergency, a cancellation made less than 48 hours in advance will automatically result in a $50 fee, which must be paid before further services are rendered. If the client fails to attend the scheduled appointment and no contact is made prior, the full fee of the session will be charged to the client's credit card on file.

Ending Therapy

I understand that I can terminate therapy at any point. If I decide I want to terminate treatment but have a scheduled appointment, I understand I will be billed and held responsible to pay for that appointment if I fail to call and cancel the appointment at least 48 hours before the scheduled date and time.

Confidentiality

I understand that this agreement becomes part of my psychological record, which is accessible to me as the client, but to no other person without my written consent or a proper subpoena. Highland Park Psychological Services will respect my right to maintain confidentiality of information communicated by me or obtained from me during the treatment period. I understand that there are legal limitations of such confidentiality (*e.g.*, cases of suspected child or elder abuse, fear of danger to self or others, or in the event that information is ordered to released pursuant to a proper subpoena and court order).

Please ask before signing below if you have any questions about our office policies. Your signature indicates that you have read and understand our office policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate your therapy if you do not comply with the policies or if your therapist concludes that you are not benefiting from treatment. This agreement covers the entire period of our relationship.

Patient/Guardian:____________________________________Date:________________

Child Over 12:_______________________________________Date:________________