CCCW | Chicago Center for Cognitive Wellness

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CCCW OUTPATIENT SERVICES CONTRACT

Welcome to the Chicago Center for Cognitive Wellness (CCCW). This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so you can discuss them with your provider. When you sign this document, it will represent an agreement between you, your provider and the practice.

PSYCHOLOGICAL SERVICES

Neuropsychological Assessment

Neuropsychological Assessment involves the objective testing of thinking skills through a multi-hour appointment that may last 2-8 hours depending on many factors including but not limited to the purpose of the evaluation and the referral question, as well as your age and stamina.

Neuropsychological Assessment can have benefits and risks. Because assessments often involve discussing unpleasant aspects of your life and the completion of challenging tests, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, neuropsychological assessment has also been shown to have benefits for people who go through it. Quantification of your thinking skills can shape rehabilitation and treatment efforts, if any are warranted, and can help you shape the goals that you have for your life. The assessment will likely be challenging as the tests are designed to assess a person's maximum ability; thus, you will not get every answer right. Please notify your examiner if you feel anxious, tired or need a break.

The results of your assessment will not be available on the day of your evaluation, and it typically takes about 4 weeks for your neuropsychologist to compile and interpret your results. At the end of that waiting period you will receive a detailed assessment report complete with treatment recommendations. Your neuropsychologist will also send this report to the referring or treating professionals you identify by providing your consent on a separate form.

Psychotherapy & Cognitive Rehabilitation

Psychotherapy & Cognitive Rehabilitation are not easily described in general statements. These treatments vary depending on the personalities of the therapist and patient, the problems you hope to address, your specific cognitive deficits (if any) and your resources and motivation. There are many different methods your provider may use to deal with those problems. Psychotherapy & Cognitive Rehabilitation sessions are not like a medical doctor visit. Instead, these treatments call for very active effort on your part. For the treatments to be most successful, you will have to work on things both during your sessions and at home.

Psychotherapy & Cognitive Rehabilitation can have benefits and risks. Because these treatments often involve discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, these treatments have also been shown to have benefits for people who receive them including better functioning, greater independence, better relationships, solutions to specific problems, and significant reductions in feelings of distress. But, there are no guarantees as to what you will experience.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some first impressions of what your work will include and a treatment plan to follow. You should evaluate this information along with your own opinions about whether you feel comfortable working with your provider and the proposed plan. Although not typical, at the end of the evaluation, your provider will notify you if he or she believes that he or she is not the right provider for you and, if so, will give you referrals to other practitioners whom your provider believes are better suited to help you.

These treatments can involve a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your provider's procedures, please discuss them with your provider. If your doubts persist, we will be happy to help you set up a meeting with another professional for a second opinion.

PROFESSIONAL FEES

The hourly fee is $250 (This fee will be billed to your insurance if we participate in your network; therefore, most patients do not pay the full fee out of pocket. However, you are responsible for charges not covered by insurance.) Meetings lasting more than the usual time will be charged accordingly. In addition to weekly appointments, providers charge this same hourly rate for other professional services you may need, though we will prorate the hourly cost if your provider works for periods of less than one hour. Other professional services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for any professional time he or she spends on your legal matter, even if the request comes from another party. We charge $250 per hour for professional services we are asked or required to perform in relation to your legal matters; depositions are billed at a flat rate of $2000 for up to 2 hours of deposition time and then $500 per half hour beyond that. We also charge a copying fee of $1 per page for records requests.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when such services are requested. In circumstances of unusual financial hardship, your provider may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, the costs will be included in the claim. In most collection situations, the only information your provider will release is the patient's name, the dates, times, and nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

Understanding Your Coverage

For us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of CCCW's fees. It is very important that you understand exactly what mental health services your insurance policy covers.

As a routine part of starting treatment, we will verify your insurance coverage before your first appointment and discuss with you our best understanding of your coverage and out-of-pocket expenses. However, you should also carefully read the section in your insurance coverage booklet that describes both your medical and mental health coverage. If you have questions about the coverage, you can call your plan administrator. We are also happy to help you in understanding the information received from your insurance company, and if necessary, we are willing to call the insurance company on your behalf to obtain clarification.

Authorizations

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans often require authorization before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions. Though a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by the insurance contract.

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

You should also be aware that most insurance companies require that we provide them with your clinical diagnosis. Sometimes we must provide additional clinical information, such as treatment plans, progress notes or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any records we submit, if you request it. ***You understand that, by using your insurance, you authorize us to release such information to your insurance company. We will try to keep that information limited to the minimum necessary.*** **[See Authorization Below]**

CONTACTING ME

I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voicemail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your psychiatrist or go to your nearest hospital emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

ELECTRONIC COMMUNICATIONS

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law.

If you have any questions about this policy, please feel free to discuss this with your provider.

Email Communications

We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email your provider about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter, please feel free to call your provider to discuss it on the phone or wait so you and your providers can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

Text Messaging

Because text messaging is a very unsecure and impersonal mode of communication, we do not text message to nor do we respond to text messages from anyone in treatment with us. So, please do not text message your provider unless you have made other arrangements.

Social Media

We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if your provider discovers that he or she has accidentally established an online relationship with you, your provider will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

We participate on various social networks, but not in our clinical capacities. If you have an online presence, there is a possibility that you may encounter your provider by accident. If that occurs, please discuss it with him or her during your time together. We believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact your provider(s) in this way. We will not respond and will terminate any online contact no matter how accidental.

Websites
We have a website that you are free to access. We use it for professional reasons to provide information to others about our practice. You are welcome to access and review the information that we have on our website and, if you have questions about it, you should discuss this during your therapy sessions.

Web Searches
We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather professional information about us in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about one of us through web searches, or in any other fashion for that matter, please discuss this with your provider during your time together so that you both can address it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of our clinicians or any professional with whom you are working, please share it with your provider so you can discuss it and its potential impact on your therapy. Please do not rate our work with you while you are in treatment with us on any of these websites. This is because it has a significant potential to damage our ability to work together.

CONFIDENTIALITY

Communications between CCCW and the client are deemed confidential as stated under Illinois state law and are protected by law. We can only release information about our work to others with your written permission. **But there are a few exceptions:**

- If the fee for this treatment is being paid by an insurance company or other agency, it may be necessary to send a copy of the clinic notes to that agency to secure reimbursement, as noted in the signed Authorization for Payment of Benefits (below) and the Release of Information for Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services (above).
- The client may request that notes be sent to another person or agency at any time in the future by completing an additional Release of Information.
- Any information discussed with your provider, including clinic notes, is confidential, and it will not be shared without written permission except under the following conditions (State law mandates that mental health professionals may need to report these situations to the appropriate persons or agencies). If a similar situation occurs in the course of our work together, your provider will attempt to fully discuss it with you before taking any action:
    - If a provider believes that a patient is **threatening serious bodily harm to another** (including murder, assault, or other physical harm), he or she may be required to take protective actions. These actions may include contacting the police or seeking hospitalization for the patient.
    - If the patient threatens suicide or threatens to harm himself/herself, a provider may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.
    - If your provider believes that a child, elderly person or disabled person is being abused or has been abused, he or she may be required to make a report to the appropriate state agency.
- In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some **legal proceedings,** however, a judge may order my testimony if he/she determines that the issues demand it, and I must comply with that court order. If you are involved in a legal action and claims mental health issues

related to the legal action (i.e., plea of "Not Guilty by Reason of Insanity," or claiming emotional harm in a lawsuit), the release of mental health records may be requested.

Your provider may occasionally find it helpful to consult other professionals about a case. During a consultation, your provider will make every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential. Ordinarily, your provider will not tell you about these consultations unless he or she believe that it is important to your work together.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that you and your provider discuss any questions or concerns that you may have at your next meeting. Your provider will be happy to discuss these issues with you and provide clarification when possible. However, if you need specific clarification or advice that your provider is unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex and we are not attorneys.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your treatment at CCCW.

ALL SIGNATURES CONTAINED HEREIN APPLY TO SERVICES RENDERED AT:
CHIGAGO CENTER FOR COGNITIVE WELLNESS

Informed Consent for Treatment:
I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature_____Date_____

Relationship to patient (if applicable)_____

Authorization for Payment of Benefits:
I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name_____Date_____

Patient OR Guarantor Signature (if patient is a minor)_____

Medicare Authorization and Assignment of Benefits:
I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature_____Date_____

HIPAA Privacy Notice Acknowledgement:
I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature_____Date_____

CCCW OFFICE POLICIES

_____ **24-Hour Cancellation Policy / Late Cancellation Fee**
If you wish to cancel an appointment, please contact your provider directly through his or her preferred method of communication (telephone number, email, etc) at least 24-hours in advance of your scheduled appointment. **Cancellations made less than 24-hours in advance, including no-show appointments, are subject to a fee of $150** to be paid prior to the next scheduled appointment. **Please note that insurance does not cover this type of charge**, and it will be billed to you directly. An outstanding balance of two (2) or more cancellation fees ($300 or more) may be considered grounds for termination of treatment until the balance has been resolved.

_____ **Returned Check / ACH / Non-sufficient Funds (NSF) Fee**
CCCW accepts payments in the form of cash, check, credit card or Chase Quickpay. If your payment results in a lack of payment due to non-sufficient funds (NSF, for example a returned check), a $35 fee will be applied to your account for each NSF occurrence. After two (2) such fees you will be required to pay by cash or credit card.

_____ **Emergency Contact**
- If you experience a life-threatening emergency, including but not limited to belief that you pose an imminent risk to yourself or someone else, it is important that you call an emergency number issued by your psychiatrist or 911 or go to your closest hospital emergency room.
- If you need emergency support between sessions, in situations that are not a life-threatening emergency, then call your provider via his or her preferred emergency contact number.
- If your provider is on vacation or a leave of absence, another CCCW provider will provide you with non-life-threatening emergency support. To reach this provider call 855-264-9355 (855-COGWELL).
- Please list the name and telephone number of the person you wish your provider to contact in the event of an emergency:

Emergency Contact Name _____

Relationship _____ Phone _____

Financial Obligations - Card on File Agreement

I hereby authorize Sherrie D All, PhD PC (DBA: Chicago Center for Cognitive Wellness or CCCW) to keep my account information on file for payment and to initiate debit or charge entries on this account as amounts are owed for the Patient Account listed above. I acknowledge that the origination of Automated Clearinghouse (ACH) or credit card transactions to my account must comply with the provisions of the U.S. law. I understand that a debit charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify CCCW. This authorization shall remain in effect until CCCW has received written notification from me of its termination. In the event of returned ACH or a declined charge, my account will be charged a service fee for each occurrence.

Signature _____ Date _____