IRVING &
ASSOCIATES IN
BEHAVIORAL HEALTH, P.C.

5151 Mochel Drive, Suite 307
Downers Grove, IL 60515

Professional Service Agreement & Notice of Privacy Practices

This notice describes important information about professional services and business policies.

AND

This notice describes how medical information may be used and disclosed, as well as how you can get access to this information.

PLEASE REVIEW IT CAREFULLY

I ________________________ (print name) have received the attached service agreement and notice of privacy.

____ __________________________________

Client Signature (age 12 and older) Date

____ __________________________________

Print Name of Client Date of Birth

____ __________________________________

Signature of Parent/Legal Guardian Relationship to Client

____ __________________________________

Witness Date

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Professional Service Agreement

This agreement contains important information about professional services and business policies. It also contains a summary of information about the Health Insurance Portability Act (HIPAA), a federal law that provides privacy protections and patient's rights with regard to disclosure and use of your protected health information used for the purpose of treatment, payment, and health care operations.

The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read through them carefully. If you have any questions, please feel free to ask at any time. Your signature on this document represents an agreement between us. You may revoke this agreement at any time by providing a written request.

As a client with Irving & Associate in Behavioral Health, you agree to the following:

1. Once an appointment is scheduled, you will be expected to pay for this time. If you choose to cancel your appointment, we require **24 hours** advance notice. A **$50.00 fee** will be charged for cancellations with less than **24 hours notice.** If you fail to show up for an appointment you will be charged your full fee for the appointment. **INSURANCE COMPANIES DO NOT PROVIDE REIMBURSTMENT FOR CANCELLATIONS OR NO SHOW APPOINTMENTS. THIS WILL BE YOUR RESPONSIBILITY. Payment for the missed appointment is required prior to or at the beginning of the next appointment.** Please note that service may be terminated due to multiple missed appointments.

2. **Payment for treatment is due at the time services are rendered.** We ask that you pay your co-pay/co-insurance at the time services are rendered. If you have not met your deductible we ask that you pay a minimum of 50% of the fee at each session until your deductible is satisfied. Payments may be made by cash, check, or credit card. Visa, Master, and Discovery cards are acceptable forms of payment for amounts $50.00 and over. You may put a credit card on file for any charges not covered by insurance. If you balance exceeds $300.00, we request that you pay for services when rendered. Services may be terminated due to non-payment. Any payment received from co-insurance payers (i.e. insurance companies or any other party) will be promptly credited to your account. This office does file for secondary insurance; please provide both insurance cards so that your provider can obtain copies of the cards. At your request, documentation of your visit will be provided to you.

3. The client/guardian is and shall be primarily responsible for any amount due and owing. It is also agreed that you, as the client/guardian, shall be responsible for any legal costs and/or expenses incurred in collecting any amount past due for non-payment. These sums will be added to any outstanding balance due and owing. The fee for returned or insufficient checks is $25.00 per occurrence.

4. Assignment of benefits to the insurance company does not release the client/guardian from responsibility of payment. If for some reason your insurance company does not cover services rendered, you will be responsible for the remaining balance. Any outstanding insurance balance beyond 90 days will be billed to the appropriate responsible party and is due upon receipt.
5. Services may include, but are not limited to: individual, family, marital, and group psychotherapy and psychological evaluation. Other services include: report writing, any telephone conversation lasting longer than ten minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and time spent performing any other service you may request. If you become involved in legal proceedings that require a therapists' participation, you will be expected to pay for all professional time, including preparation and travel expenses.
6. This office reserves the right to change, modify, or alter any of the terms of this agreement in the future, upon first giving notice to you. Any objections to the changes, modifications, or alterations, must be made promptly upon receipt of this notice. If no objections are made, it shall be assumed that you have accepted the changes, modifications, or alterations made.
7. Please be aware that insurance companies require a clinical diagnosis for billing purposes. This information may become part of your permanent medical record. If you have any questions, please discuss this with your therapist.

COORDINATION OF TREATMENT:

It is important that health providers communicate and 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, but can be revoked at any time. 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: ____

ADDRESS: ____

PHONE: ____

____ _______________________

CLIENT SIGNATURE DATE