INFORMED CONSENT

Thank you for choosing Julie S. Blackburn, LCPC, NCC, ATR with the Chartreuse Center. The initial appointment will take approximately 75 minutes and subsequent appointments will be approximately 45 – 55 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. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Julie S. Blackburn, LPCP, NCC, ATR has earned a Bachelor of Arts Degree in Communication from Western Illinois University and a Masters Degree in Counseling Psychology and Art Therapy from Adler University. She is licensed by the State of Illinois as a Licensed Clinical Professional Counselor, nationally recognized as a Nationally Certified Counselor and Registered Art Therapist. In 2009, she began her clinical experience in treating adolescents, adults and families using individual, family and group therapy. Julie S. Blackburn, LCPC, NCC, ATR practices standard Art Therapy, Client Centered and Adlerian therapy for most conditions. Although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan imitations and risks 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. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the office to have a counselor paged. If no call is received within 15 minutes, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Julie S. Blackburn, LCPC, NCC, ATR will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and the therapist may not be able to respond.

Initial(s) _____

FINANCIAL/INSURANCE ISSUES:

As a courtesy, we will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. 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 $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Chartreuse Center.

☐ I have received a copy of my fee schedule **Initial(s)** _____

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CANCELLATION POLICY:

If you need to cancel or reschedule an appointment, please give 24 business hours advance notice. The first missed session is at no cost. Subsequent missed sessions will be billed at the hourly rate. 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.**

☐ I authorize use of a credit card on file to bill for missed appointments and appointments cancelled with less than 24 hour notice since insurance will not pay for those sessions.
☐ I understand I am responsible for the fees for missed appointments and appointments cancelled with less than 24 hours notice. I would like a bill sent to me.

Initial(s) _____

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 inform will be shared.

☐ You may inform my physician(s) and I have completed a Release of Information
☐ I decline to inform my physician

Initial(s) _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

☐ I/We have read and received a copy of the, Notice of Privacy Practices.
☐ I/We have read and received Client Rights document.

Initial(s) _____

_____	_____
Print Name	**Print Name**
_____	_____
Signature	**Signature**
_____	_____
Print Name	**Print Name**
_____	_____
Signature	**Signature**
_____	**Date_____/_____/_____**

Julie S. Blackburn, LCPC, NCC, ATR