



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

• fax: (847) 573-1617

www.hawthorncounseling.com

---

## Patient Registration Instructions—Please Read Before Completing Forms

We wish to take this opportunity to welcome you to our practice, Hawthorn Counseling Group (HCG). We look forward to collaborating with you in achieving your goals for counseling. Please take a few minutes to review and complete the attached forms, bringing them with you to your first appointment. Please also review the following information:

- ✓ Please review the *Consent for Treatment* form in its entirety. If you wish to use health insurance to offset the costs of counseling, it is recommended that you contact your health insurance company prior to the first appointment to determine: 1) if your policy has a restricted network of providers; 2) if your HCG clinician is in your network; 3) the amount of any deductible which must be met; 4) the amount of any copays once the deductible is satisfied; 5) any restrictions upon mental health benefits or the need for authorization of care.
- ✓ If you wish HCG to bill your insurance company, please sign the written release to disclose information on the attached form.
- ✓ Your HIPPA privacy rights are summarized on two sheets of information—these pages are yours to keep—and we ask that you sign the attached form indicating that you have been provided with this information.
- ✓ Please review and complete the attached *Payment Agreement*, providing credit card billing information in the space provided. As explained on the form, you may use cash or check to pay for services, however your credit card may be utilized for collection of unpaid balances resulting from deductibles, copays, late cancellation or failed appointment charges. Please be sure to check the appropriate boxes indicating how you wish to make payment for services, complete credit card information before signing the *Payment Agreement* at the bottom.

Please take special note of information found in both the *Consent for Treatment* and *Patient Rights & Responsibilities* forms regarding our policy concerning late cancellations or failed appointments:

- You will benefit most from your course of counseling if you make it a scheduling priority. However, we know that it can be difficult to juggle commitments and we will work to accommodate your needs.
- If you need to reschedule an appointment, Hawthorn Counseling Group requires at least 24 hours' notice—a *full business day in advance of the hour of your appointment*—for you to give us notice of your need to cancel a scheduled appointment. Take special note of the following: appointments scheduled on Mondays (or Tuesdays if following a holiday weekend) must be canceled by 5:00pm the preceding Friday afternoon. If you have a scheduling conflict and need to cancel an appointment it is sufficient to leave a voicemail message in your specific clinician's voicemail box by calling 847-680-0755, then entering the mailbox extension for your HCG clinician. Please contact us at least 24 hours (or one business day) in advance of the hour of the scheduled appointment in order to avoid being billed for the appointment. It is our practice to make allowances or exceptions to this policy in the event of sudden serious illness, family emergency or severe inclement weather. Please know, though, that business/work conflicts, scheduling of kids' athletic or school events, unexpected business travel or other similar circumstances which might arise are not deemed as grounds for waiver of the late cancellation policy.
- If you are the guarantor of your son or daughter, and they are of age to make their own scheduling arrangements for counseling visits, you will want to stay informed of appointment scheduling to support their attendance, since you will ultimately be responsible for charges. We would be happy to coordinate scheduling information via email or phone—let us know your preference and provide the necessary contact information.
- Should a late cancellation or failed appointment occur you will be charged the full usual and customary fee for the scheduled service as shown on the attached fee schedule. Your insurance company will not be billed for the late cancellation or failed appointment—you will be responsible for payment of the full usual and customary fee per the HCG fee schedule. In the event that you incur such a charge we ask that you provide payment prior to or at time of the next scheduled appointment.



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

fax: (847) 573-1617

www.hawthorncounseling.com

## PATIENT REGISTRATION INFORMATION – *please print clearly & legibly*

<b><i>Patient Information</i></b>					
Last Name	First Name	MI	Date of Birth / /	Age	Sex
Address	Apt. #	City	State	Zip	
Patient Social Security Number	Home Phone	Work Phone	Cell Phone		
Patient Employed By			Occupation		
If contact by email for scheduling, billing or other matters is convenient, please provide email address:					
<b><i>Guarantor--Name of Person Financially Responsible for Patient's Care (Provide this information only when guarantor is not the patient)</i></b>					
Last Name	First Name	MI	Date of Birth / /	Age	Sex
Address	Apt. #	City	State	Zip	
Guarantor Social Security Number	Home Phone	Work Phone	Cell Phone		
Guarantor Employed By			Occupation		
If contact by email for scheduling, billing or other matters is convenient, please provide email address:					
<b><i>Health Insurance Information (may be left blank if a copy of insurance card—both front &amp; back— is obtained)</i></b>					
Name of Insurance Company		Name of Subscriber		Relation to patient	
Plan/Policy #	Group #		Effective Date, if known		
Insurance Company Claims Billing Address			City	State	Zip



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

fax: (847) 573-1617

www.hawthorncounseling.com

## CONSENT FOR TREATMENT

Patient Name: \_\_\_\_\_

- 1) I hereby consent to receive behavioral health services provided by the mental health professionals affiliated with Hawthorn Counseling Group (HCG).
- 2) I authorize and request that HCG perform assessments and to administer those treatments as may be considered advisable in making a diagnosis and treating my condition. I understand that individual and family psychotherapy sessions are typically of 45 minutes duration and will be billed accordingly. Sessions of longer duration (e.g., 55-60 min), will be provided either at my request, when clinically indicated or at the clinician's discretion and will be billed according to the HCG fee schedule in effect at the time of service.
- 3) I realize that no particular outcome or result can be guaranteed as a result of my consent to receive treatment by HCG.
- 4) I hereby release HCG from responsibility for any injury which may result from my declining services recommended by HCG or terminating services against clinical and/or medical advice.
- 5) I have read, understood and signed the *Patient Rights, Responsibilities and Statement on Confidentiality* and agree that I will follow the procedures described therein, specifically including the following:
  - a) HCG requires notice by telephone no later than one business day—24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon).
  - b) If I do not give proper notification I understand that I am responsible for paying the full customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, for the missed appointment (not a reduced/contracted fee or the customary co-pay charge).
    - i) Failed appointments will result in my being billed the full customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, and I understand that no claim will be submitted to my insurance company for this charge.
    - ii) Late cancellations (e.g., cancellation without adequate advance notice specified above in par 5a) will result in being charged the full customary charge except when due to instances of unforeseen events such as sudden illness, family emergency or severe inclement weather. Personal scheduling conflicts (e.g., due to employment or other circumstances) shall not be eligible grounds for waiver of the late cancellation charge.
  - c) HCG kindly requests that payment for failed appointments and/or late cancellations be provided in full at the next scheduled appointment.
- 6) Non-urgent calls (e.g., scheduling or other non-urgent matters) are best managed by making use of the HCG voicemail system at (847) 680-0755, leaving a message for the specific provider. In the event of an after hours emergency, it is recommended that patients contact the treating clinician as instructed on the HCG voicemail service or contact the nearest hospital emergency room.
- 7) I have been given the opportunity to review the HCG fee schedule. I understand that I am responsible for making payment for each session immediately following each appointment as set forth in the accompanying Payment Agreement.
- 8) If electing to use health insurance, I understand that not all services provided by HCG may be covered under my plan and, further, that I am still ultimately responsible for payment for all services provided.

***I certify that I have read the above information and signify my agreement with my signature below:***

X \_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Date



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

• fax: (847) 573-1617

www.hawthorncounseling.com

## PATIENT RIGHTS & RESPONSIBILITIES

Patient Name: \_\_\_\_\_

### As a Consumer of Healthcare Services, Your Rights Include The Following

- ✓ To individualized service, to participate in treatment planning and to see your clinical record.
- ✓ To be advised at the time that treatment is initiated of the cost of the services to be provided.
- ✓ To know the professional status, licensure, training and experience of the staff members responsible for your treatment.
- ✓ To confidentiality of all records and communications, within the extent prescribed by law (see below), including the confidential handling of personal and medical records and to approve or refuse the release or records to any individual outside Hawthorn Counseling Group (HCG).
- ✓ Upon request, to know the risks, side effects, benefits and/or experimental nature of all treatment procedures and to be advised of known alternate treatment procedures available, their indications and foreseeable outcome.
- ✓ Upon request, to a clear and concise explanation of the proposed treatment and procedures, the goals of treatment and anticipated outcome of treatment.
- ✓ To refuse treatment. Should you choose to refuse recommended treatment, you shall be provided, upon request, a clear description of anticipated consequences of the decision to refuse treatment to the extent these consequences are foreseeable.
- ✓ To request the opinion of a consultant at personal expense and to request a review of your treatment plan.

### As a Consumer of Healthcare Services, Your Responsibilities Include The Following

#### **Missed appointments & late cancellation policy**

You are responsible for scheduling and keeping appointments with the treating clinician. HCG requires notice by telephone no later than 24 hours in advance of a scheduled appointment (or for Monday appointments and Tuesday appointments which follow holiday weekends, no later than 5:00pm on the preceding Friday afternoon). It is sufficient to leave a voicemail message for your specific clinician when calling to cancel a scheduled appointment. Please note that patients are responsible for payment of the full usual & customary fee, per the HCG fee schedule in effect at the time the appointment was scheduled, for a failed appointment or late cancellation. Please note, too, that your insurance company will not be billed for the late cancellation or failed appointment. *Other than circumstances such as sudden illness, family emergency or severe inclement weather, we are unable to make exceptions to this policy.*

#### **Fees**

Fees are discussed and set at the time of the initial appointment, based upon the HCG fee schedule in effect at the time of service delivery, which is available for review upon request. Expected fees for some services are shown on the *Consent for Treatment* form. Payment arrangements are detailed on the *Payment Agreement* form. Collections procedures for HCG are described in policy, which is available for review upon request. In the case of prolonged nonpayment for services per the HCG fee schedule in effect at the time the appointment was scheduled reserves the right to implement its collections policy which could include the use of collections agencies, alternative dispute resolution procedures and/or small claims court filing.

#### **Use of health insurance**

Some services provided by HCG may be eligible for reimbursement by your health insurance. If you plan to use health insurance benefits, your HCG clinician will work with you to comply with the requirements of your insurance and/or managed care company. Your treating clinician will arrange to have claims filed with your insurance company if you so desire. However, you are ultimately responsible for payment for all services, including payment for denied services, within contractual limitations and in accordance with the terms set forth in the accompanying *Payment Agreement*. Additionally, you are responsible for participating in any appeals processes for denied claims. Finally, please note that some services may not be eligible for insurance reimbursement (e.g., phone consultations, report writing, etc.).

### **Information Concerning Confidentiality**

As a recipient of psychological services through HCG, your treatment is confidential within the limits prescribed by law. In general, no information about you or your treatment will be released to anyone without your written permission. However, relevant laws require that your therapist contact others about your safety if you present a danger to yourself and/or others, or if your therapist learns of child abuse/neglect or, under certain circumstances, if so ordered by a court. In addition, your therapist may consult with a clinical supervisor, or other qualified clinician, without your consent to improve the quality of care provided. If the recipient of services is under 12 years of age, your therapist may discuss the treatment with the recipient's parent or legal guardian without consent. If the recipient is 12 through 17 years of age, the therapist may discuss the treatment with a parent or legal guardian when the recipient is informed and does not object to sharing information with his/her parent or guardian, or if the therapist does not feel there are compelling reasons not to disclose information with the parent or guardian. Information may also be disclosed to the guardian of a recipient who is 18 years or older. Information may also be disclosed to outside agencies & organizations to support collections and billing procedures. Otherwise, except as provided by law, no information may be disclosed without the written consent of a recipient who is 18 years or older. Further information on confidentiality is provided in the related Privacy Notice, provided at time of intake.

***I certify that I have read the above information and signify my agreement with my signature below:***

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_ Date



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

fax: (847) 573-1617

www.hawthorncounseling.com

Patient Name: \_\_\_\_\_

## RELEASE OF INFORMATION FOR PROCESSING HEALTH INSURANCE CLAIMS/CHARGES & CONSENT FOR ASSIGNMENT OF BENEFITS

I hereby authorize Hawthorn Counseling Group (HCG) to release any of the following information for the purpose of obtaining reimbursement for treatment services provided to me and/or my dependents. Information to be released may include:

- |   |   |
|---|---|
| 1. Admitting diagnosis                    | 5. Progress notes                             |
| 2. Treatment summary/dates of service     | 6. Treatment plan                             |
| 3. Billing summary & charges              | 7. Final diagnosis and/or termination summary |
| 4. Verbal/written exchange of information |   |

This information may be released to any or all of the following parties/organizations as needed:

- |  |   |
|--|---|
| 1. Any third-party payor having responsibility for payment of charges incurred through rendering of psychological services by HCG. | 4. Collection agencies utilized by HCG.   |
| 2. Review agents or auditors of third party payors   | 5. Legal representatives related to small claims court processing (e.g., court representatives, judges, attorneys). |
| 3. Managed care utilization review agents  |   |

This consent is valid until such time that all claims have been settled to the satisfaction of HCG or up to three years from the date of discharge from HCG, whichever is longer. I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize HCG to contact the actual or additional insured (e.g., my spouse or other guarantor), and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate this consent at any time before the expiration date so long as I submit my revocation in writing to HCG. Finally, this consent does not permit any agency reviewing clinical information and/or records to redisclose my records to any other agency/person/organization without my written consent.

I understand that I am ultimately responsible for any and all charges not paid by my medical insurance carrier, as described in the accompanying Payment Agreement, and that if I refuse to sign this release of information form I will likely have to pay for any and all charges incurred, without utilizing health insurance benefits.

I certify that I am the client; if I am not the client I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of Parent / Guardian                      Date

**ASSIGNMENT OF BENEFITS:** In consideration of services to be provided to me or to my dependent I hereby assign, transfer and set over HCG all of my rights, title and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits as they pertain to charges incurred for services rendered by HCG. I understand that I am financially responsible to HCG for charges not covered by my insurance and/or managed care company by this assignment for any reason

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of Parent / Guardian                      Date



## **PRIVACY NOTICE Notice of Policies and Practices to Protect the Privacy of Your Health Information**

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### **I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Hawthorn Counseling Group (hereafter referred to as "HCG") may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when HCG provides, coordinates, or manages your health care and other services related to your health care. An example of treatment would be when HCG consults with another health care provider, such as your family physician or another psychologist.
  - Payment is when HCG obtains reimbursement for your healthcare. Examples of payment are when HCG disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of HCG. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within HCG offices such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my HGC offices such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is the patient's written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

### **II. Other Uses and Disclosures Requiring Authorization**

HCG may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when HCG is asked for information for purposes outside of treatment, payment, or health care operations, HCG will obtain an authorization from you before releasing this information. HCG will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes made about conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that HCG has already relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage—law provides the insurer the right to contest the claim under the policy.

### **III. Uses and Disclosures without Authorization**

HCG may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If HCG has reasonable cause to believe a child known through a professional capacity may be an abused child or a neglected child, HCG must report this belief to the appropriate authorities.
- Adult and Domestic Abuse – If HCG has reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, HCG must report this belief to the appropriate authorities.
- Health Oversight Activities – HCG may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and HCG must not release such information without a court order. HCG can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to HCG a specific threat of imminent harm against another individual or if an HCG clinician believes that there is clear, imminent risk of physical or mental injury being inflicted against another individual, HCG may make disclosures believed necessary to protect that individual from harm. If HCG believes that you present an imminent, serious risk of physical or mental injury or death to yourself, HCG may make whatever disclosures considered necessary to protect you from harm.
- Worker's Compensation – HCG may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

#### **IV. Patient's Rights and Psychologist's Duties**

##### **Patient's Rights:**

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, HCG is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, HCG will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, HCG will discuss with you the details of the request for access process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. HCG may deny your request. On your request, HCG will discuss with you the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, HCG will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

##### **Psychologist's Duties:**

- HCG clinicians are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.
- HCG reserves the right to change the privacy policies and practices described in this notice. Unless notified of such changes, however, HCG is required to abide by the terms currently in effect.

#### **V. Complaints**

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact HCG or John D. Jochem, Psy.D., or contact the Illinois Guardianship & Advocacy Commission. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

#### **VI. Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on March 1, 2003.



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

● fax: (847) 573-1617

www.hawthorncounseling.com

---

Patient Name: \_\_\_\_\_

## PRIVACY NOTICE ACKNOWLEDGMENT

By signing below, I acknowledge that I have received a copy of *Notice of Policies and Practices to Protect the Privacy of Your Health Information* regarding the care I am receiving through Hawthorn Counseling Group.

X \_\_\_\_\_  
Signature of Patient

X \_\_\_\_\_  
Signature of Parent / Guardian      Date





# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

fax: (847) 573-1617

www.hawthorncounseling.com

## Hawthorn Counseling Group Fee Schedule

	Licensed Clinical Social Worker	Licensed Clinical Psychologist
<b>Psychotherapy Services</b>		
90791, Diagnostic Evaluation / initial consultation (60 min)	\$160.00	\$220.00
90832, Psychotherapy with patient and/or family member (30 min)	\$80.00	\$110.00
90834, Psychotherapy with patient and/or family member (45 min)	\$120.00	\$165.00
90837, Psychotherapy with patient and/or family member (60 min)	\$160.00	\$220.00
90847, Family/conjoint psychotherapy w/ patient present (45 min)	\$120.00	\$165.00
90846, Family/conjoint psychotherapy w/out patient pres (45 min)	\$120.00	\$165.00
Scheduled telephonic consultation (45 min)	\$120.00	\$165.00
<b>Evaluation Services</b>		
Fitness-for-duty evaluation <ul style="list-style-type: none"> <li>2 units 90899—unlisted procedure/service</li> <li>1 unit 90889—document preparation</li> </ul>	N/A	(Services provided may vary with circumstances) Est total: \$385.00
School fitness evaluation <ul style="list-style-type: none"> <li>2 units 90899—unlisted procedure/service</li> <li>1 unit 90889—document preparation</li> </ul>	N/A	(Services provided may vary with circumstances) Est total: \$385.00
Bariatric surgery evaluation <ul style="list-style-type: none"> <li>2 units 90899—unlisted procedure/service</li> <li>4 units 90889—document preparation</li> </ul>	N/A	(Services provided may vary with circumstances) Est total: \$550.00
96101. Psychological testing <ul style="list-style-type: none"> <li>MMPI / MMPI-A administration &amp; interpretation</li> </ul>	N/A	\$150.00
90889, Document preparation / report writing (15 min)	\$40.00	\$55.00
90899, Unlisted procedure or service (45 min)	\$120.00	\$165.00
99362—Staffing/meeting attendance (60 min)	\$160.00	\$220.00
<b>Collaborative Divorce, Parent Coordination &amp; Medication Services</b>		
Collaborative divorce services <ul style="list-style-type: none"> <li>Coaching and/or child specialist services (60 min)</li> <li>Team meeting attendance (60 min)</li> <li>Report preparation (per 15 min)</li> <li>Travel, RT, door-to-door (per 15 min)</li> <li>Telephonic conferences (per 15 min)</li> </ul>	\$160.00 \$160.00 \$40.00 \$40.00 \$40.00	\$220.00 \$220.00 \$55.00 \$55.00 \$55.00
Parent coordination services <ul style="list-style-type: none"> <li>Evaluation &amp; parent coordination sessions (60 min)</li> <li>Report preparation (per 15 min)</li> <li>Travel, RT, door-to-door (per 15 min)</li> <li>Telephonic conference (per 15 min)</li> </ul>	\$160.00 \$40.00 \$40.00 \$40.00	\$220.00 \$55.00 \$55.00 \$55.00
Mediation services <ul style="list-style-type: none"> <li>Mediation services (60 min)</li> <li>Report preparation (per 15 min)</li> <li>Travel, RT, door-to-door (per 15 min)</li> <li>Telephonic conference (per 15 min)</li> </ul>	\$160.00 \$40.00 \$40.00 \$40.00	\$220.00 \$55.00 \$55.00 \$55.00

The above CPT codes are based upon guidelines developed by the American Medical Association. Fees shown represent usual & customary rates for Hawthorn Counseling Group (HCG) services. Effective January 1, 2014



# Hawthorn Counseling Group

977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061

(847) 680-0755

• fax: (847) 573-1617

www.hawthorncounseling.com

## PAYMENT AGREEMENT

Patient Name: \_\_\_\_\_

In consideration of the services to be rendered by the clinicians of Hawthorn Counseling Group (HCG), the undersigned agrees, as patient or guarantor for patient, to pay HCG for all services provided to the patient, at the established rates listed in the HCG fee schedule in effect at the time services are received or to make payments in accordance with contractual rates between HCG and the patient's insurance company/third-party payor in effect at the time services are received. Payments will include any deductibles, co-payments and all other charges not covered by third-party payors, including failed appointment & late cancellation charges. I certify that the information given by me to HCG for purposes of payment is, to the best of my knowledge, complete and accurate. I will make arrangements for prompt and regular payment of fees to HCG for services. I understand that payment is due either in-full or in-part at the time services are provided, as arranged when services are initiated. I grant permission to HCG to utilize my credit card account, flex spending account or retainer for payment of any unpaid balances 30 days or more past due, including co-payments, deductibles, failed appointment & late cancellation charges. Credit card charges will show on billing statements as "Hawthorn Counseling Group".

### Payment for Psychotherapy Services (*choose option 1 or 2*)

**1** I will make **payment in-full** at the time of each session. Upon my request, HCG will submit claims to my health insurance company on my behalf for reimbursement of my expenses.

CHECK ONE BOX BELOW:

I will pay in-full by cash or check at time of each session. Checks may be made payable to *Hawthorn Counseling Group*. I have also provided credit card billing information below and authorize use by HCG for payment of any unpaid balances, including co-payments, deductibles, failed appointment & late cancellation charges.

I will pay in-full by credit card or flex spending account and have completed billing information below. I also authorize use of my credit card by HCG for payment of any unpaid balances which may accrue, including co-payments, deductibles, failed appointment & late cancellation charges.

**2** I will make **partial payment** at the time of each session, in the amount of estimated insurance plan deductibles or co-payments. Upon my request, Hawthorn Counseling Group will submit claims to my health insurance company for additional reimbursement. However, I understand that I am responsible for the payment of all fees.

CHECK ONE BOX BELOW:

I will make co-payments by cash or check at the time of each appointment. Checks may be made payable to *Hawthorn Counseling Group*. I have also provided credit card billing information below and authorize use by HCG for payment of any unpaid balances, including co-payments, deductibles, failed appointment & late cancellation charges.

I will make my co-payments by credit card or flex spending account and have completed billing information below. I also authorize use of this information by HCG for payment of any unpaid balances which may accrue, including co-payments, deductibles, failed appointment & late cancellation charges.

*All new patients to our practice are asked to provide credit card billing information below:*

TYPE OF CREDIT CARD:     VISA     M/C     FLEX SPENDING ACCOUNT     DEBIT CARD

NAME OF CARD HOLDER:

ACCOUNT NUMBER: 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

EXPIRATION DATE: 

--	--	--	--

AGREEMENT AND AUTHORIZING SIGNATURE:  
 \_\_\_\_\_

Patient     Parent/Guardian

Date