lifeworks
PSYCHOTHERAPY CENTER

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simply aware, fully alive

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lifeworkspsychotherapy.com

Psychotherapy Policies

Fees

LifeWorks' sessions are billed as follows:

	Individual Therapy	Relationship Therapy
Clinicians	$175/session	$190/session
Senior Clinicians	$190/session	$205/session

The session fee, co-pay or co-insurance amount is to be paid at the time of service.

Insurance

LifeWorks is a Blue Cross Blue Shield (BCBS) PPO & Blue Choice provider. We also have Medicare providers on staff. We will file claims with Medicare or BCBS, if you are covered by one of those plans and seeing a therapist in that provider network. If you have another insurance carrier, we can provide a monthly statement for your claim, but we cannot make the claim for you.

Regarding deductible amounts, it is your responsibility to contact your HR person or BCBS directly and determine what your deductible amount is and how much is owed and the outset of your therapy. Clients are responsible for payment for any service or fee applied to the deductible required by your policy.

If your policy with BCBS or Medicare lapses or is terminated for any reason, you are responsible for the full fee for any dates of service not covered.

Diagnosis

In order to bill insurance for psychotherapy services, you will receive a diagnosis which will be reported to my insurance company.

Cancellation Courtesy

The courtesy of 24-hour notice of cancellation of scheduled appointments is requested. Clients will be held responsible for their full session fee, if 24-hour notice is not given to their therapist. Please note your insurance carrier cannot be billed for a cancellation and you will be responsible for the cancellation fee for missed sessions. Insured clients are charged $150 for each missed session.

Depth Psychotherapy

At LifeWorks you will likely be engaging in a depth-oriented psychotherapy approach to your symptoms and that there are shorter term, evidence based therapeutic techniques available to you at other practices or upon written request.

Confidentiality

All professional and ethical guidelines will be followed in order to preserve the confidentiality of the therapeutic relationship.

Illinois law makes two limitations to client-therapist confidentiality. Therapists are required by the Abused and Neglected Children's Reporting Act to disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services, and by the Elder Abuse Act to report abuse or neglect of elders to the Department on Aging.

In addition, should a client make a disclosure about their intent to harm themselves or another person, it is the therapist's responsibility to take steps to assure the safety of the client, notify the victim and/or authorities in order to prevent harm from occurring to another person.

Outside of these instances, any specific, detailed information about the client or the client's work in therapy requires the client's personal consent and signature prior to its release. Please review the HIPAA Help folder in the reception area if you have other questions or consult www.hhs.gov/ocr/hipaa

Telephone & Electronic Communication (i.e. text, email, etc...)

If you need to contact your therapist between appointments, you may do so by telephone or electronic means (text, email, etc...). Please be aware that most electronic communications are not secure or protected channels for communication and, though unlikely, it is possible that your privacy and the security of information communicated via these media may be compromised. **If you choose** to communicate with your therapist via electronic means, you are giving your consent for your therapist to respond to you by electronic means. LifeWorks will communicate with you according to your preferences, until you notify us in writing of a change. Please indicate your preferences for communication from your therapist and/or LifeWorks in the section below.

I wish to be contacted in the following manner (please check all that apply):

Telephone Communication:

_____ Home telephone #_____

_____ Work telephone #_____

_____ Cell phone # _____ OK to text? ____ Yes ____ No

_____ Do not contact me at home. _____ Do not contact me at work.

Please let us know anything you do not want to be mentioned in a phone or text message?

_____

_____

Written Communication:

_____ email for general communication _____

_____ email for monthly statement _____

_____ Do not email me. _____ Please send all written communications by mail.

Please let us know anything you do not want to be mentioned in an email?

_____

_____

Emergency

If you are in an emergency situation or need to talk to someone right away, you should contact your nearest hospital emergency room or the police at 911.

Billing & Payment

You are expected to pay your portion (co-pay, co-insurance, out of pocket amount) of the fee for service each session unless otherwise negotiated with the therapist. You will receive a monthly statement, if you have an open balance greater than the expected insurance payment. With your written consent on the Credit Card Authorization form, your credit card can be used to pay for your portion of fees and any missed sessions you may incur. Your therapist can also help you to establish a payment plan, if needed.

I have read and understand the policies above.

_____

Client Signature Date

_____

Client Name (print)