Lantern Therapy Services, LTD

Informed Consent/Financial Arrangement

Welcome! This document contains important information about our professional services and business policies. Please read it carefully, (**particularly the areas which are in bold print**) and feel free to ask any questions.

Our first sessions will involve an evaluation of your needs and goals. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a recommended treatment plan. If you have any questions about my recommendations, we should discuss them whenever they arise.

Cancellations

We ask that if you need to cancel your appointment, please provide us at least 24 hours in advance. **A $50.00 late cancellation/ no call no show fee will be billed for sessions with last minutes cancellation or no cancellation.** Please note that insurance will not reimburse for missed sessions.

Professional Fees

My hourly fee is $150.00. I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party.

Billing and Payments

You will be expected to pay for all routine deductibles/co-payments at the end of each session. Unless other arrangements have been made with our billing department, we require a valid credit card to be placed on file. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment. We accept cash, checks, Visa, MasterCard, and Discover. There will be a $25.00 fee for returned checks. We do understand that unexpected events arise and financial hardships may affect timely payment of your bill. **We will do everything we can to help all we ask is that you contact as soon as to make arrangements.**

If your account has an outstanding for service dates that are over 60 days and a credit card has not been placed on file, a collection agency or legal means will be used to collect unpaid debt. Our office will charge a 30% administrative/collection fee should your account be turned over to our collection agency. In most collection situations, the only information we release regarding a patient are personal identifiers such as the information you have provided on our intake form (name, address, phone) and the amount due.

Insurance/Employee Assistance Programs
If you were referred by an Employee Assistance Program, you should have been provided an authorization/approval number for a certain number of sessions. **If you did not obtain authorization prior to session, you will be responsible for full payment.** Once the number of sessions authorized has been fulfilled, Lantern Therapy Services LTD will obtain approval for subsequent sessions.

Lantern Therapy Services LTD will file insurance claims. We do not bill secondary insurance claims, however we will be glad to assist you so that you may be reimbursed. After your initial session, as a courtesy, we verify insurance benefits including co-payment and deductible information regarding your plain. **We cannot guarantee accurate benefit information has been received from your insurance company until the claim has been processed. It is also up to you to check with your insurance company about limits of your coverage.** You should also be aware that most insurance companies require me to provide them with a clinical diagnosis. At times, I have to provide additional clinical information such as treatment plans or summaries.

If your insurance company does not pay your bill in full within 30 days, we ask you to contact your insurance company. We may not be party to that relationship. Your insurance policy is between you and your insurance company. Our relationship is with you as a client, and not your insurance company. **All charges are your responsibility whether your insurance pays or not.** You will need to notify us of any changes in your insurance plan. If you do not notify us, and your new policy does not cover our services, you will be billed for the full payment.

Divorce Situations
Lantern Therapy Services LTD looks to the adult who brought the child in for the appointment to be responsible for payment of services rendered to the child. We also

expect the parents to be able to work out payment arrangements with each other and not involve our office in any disputes which may arise.

DCFS Reporting

Please note that all staff at Lantern Therapy Services are mandated reporters to DCFS. All suspected child abuse will be reported to the DCFS hotline.

Attendance

It is important to attend all scheduled appointments to be able to meet treatment plan goals. If you must miss an appointment please contact your therapist as soon as possible. **Failure to attend three sessions may result in a discharge to services. Be sure to be discussing any attendance issues with your therapist.**

Court

Lantern Therapy Services reserves the right to not participate in any court events. This includes communication with attorneys.

Assignment and Release

Your signature below indicates that you have read the information in this document and agree to abide by its terms. I hereby authorize payment to be made directly to Lantern Therapy Services LTD and fully understand that I am the responsible party for all charges incurred by me or my dependent. I also authorize the release of any and all information required to collect or process my claims. If legal action becomes necessary, I agree to pay all reasonable fees.

Name of client: ____________________________________ Date___________

Signature of client or responsible party: ______________________ Date___________