



**STUDIO**  
FOR CHANGE

2801 N. Sheffield, 2<sup>nd</sup> Floor  
Chicago, Illinois 60657  
773-281-8130  
studioforchange.com

### **Child & Family Therapy Services Agreement**

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_

PARENT'S NAME \_\_\_\_\_

PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

ADDRESS \_\_\_\_\_

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### **INSURANCE INFORMATION**

INSURANCE COMPANY \_\_\_\_\_

INSURANCE ID NO. \_\_\_\_\_

GROUP NO. \_\_\_\_\_

INSURED'S NAME (if different than above) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

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REFERRED BY \_\_\_\_\_

## **Welcome to the Studio For Change®**

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between you and the Studio For Change.

### **Psychological Services**

Psychotherapy with children is not easily described in general terms. It varies depending on the personality of both the therapist and the client, the age of the client and the problem being presented. Therapy with children is a slower process than with adults because it takes a child longer to become comfortable in the environment and trusting of the therapist.

For younger children, techniques of play therapy are often utilized. Play therapy allows children to speak in their most comfortable, effective language by using games, toys, creative arts, dolls and other play materials. Children can effectively convey their fears, wishes, anxieties and thought processes through play and behavioral management.

Older children have a higher capacity to express themselves verbally, but often also need support in mastering this skill. Typically for older children a combination of talk therapy and play therapy is utilized to work through their problems and to effectively communicate their needs and feelings.

As with adults, psychotherapy with children has both risks and benefits. Risks often include the child experiencing uncomfortable feelings or a temporary increase in targeted negative behaviors. Psychotherapy with children has also been shown to have significant benefits including a reduction in feelings of distress, improved relationships, decrease in negative behaviors, and resolution of specific problems. There are no guarantees about what or when changes will occur.

The first few sessions may involve a combination of meetings with the parents and child both individually and as a family. By the end of the evaluation, your therapist will offer you impressions of what the work will include and an initial treatment plan. If you have questions about these procedures or the proposed treatment plan, you should discuss them with the therapist before moving forward with therapy.

Our therapeutic services typically include a combination of individual and family therapy. It is important for your child, parents and therapist to work as a team. It is also important that your child develops a sense of safety and trust in the therapist and the therapeutic environment. In therapy, children are provided the same confidentiality and respect as adults. Parents will be provided an overview of the progress and continued areas of focus

for your child. As well, your child will be encouraged to share concerns and feelings with the parents through engagement in family therapy. However, specific information shared by the client during the therapeutic process will not be shared with the parent unless the therapist is concerned for your child's well-being or if it is believed that sharing the information will benefit the therapeutic process.

### **Cancellation & Rescheduling Policy**

**(Parent's Initials)** The Studio For Change requires 24 hour notice for any non-emergency cancelled appointments. Therapy appointments must be cancelled or rescheduled 24 hours before the scheduled date and time. Any same day, non-emergency cancellations or not calling to cancel an appointment will result in a cancellation fee of \$75.00. For such purposes we require a credit card number on file.

### **Contacting Your Therapist**

Your child's therapist may not be immediately available by telephone. While we are usually in the office during the week, we usually do not answer the phone when with a client. When your therapist is not available, please leave a message. All voice mailboxes are confidential. Your therapist will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If you cannot reach your therapist, and you feel that you cannot wait for a return call, you should call your family physician, 911, or go to your local hospital's emergency room. If your therapist is unavailable for an extended period of time, you will be provided with the name of a trusted colleague whom you can contact as needed.

### **Drug and Alcohol Policy**

The Studio For Change requests that clients seeking services be drug and/or alcohol free during therapy appointments. That is, no illicit drugs or alcohol are to be consumed prior to a therapy session.

### **Supervision**

In order to provide the best quality services, therapists often receive clinical supervision. As well, your Studio For Change therapist may be working towards a specific level of professional licensure. Your therapist's approved clinical supervisor will have access to your client file and information. You have the right to know and contact the licensed, clinical supervisor overseeing your case at any time. All approved supervisors are held to the same confidentiality requirements as your therapist.

## *Payments & Billing*

### **Professional Fees**

\_\_\_\_\_ (Parent's Initials) Your Studio For Change therapist bills at a rate of \$160.00 per therapy hour (\$250 for the initial assessment appointment). The therapy hour is typically 45-50 minutes in length. In addition to weekly appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations with other professionals that you have authorized, preparation of records or treatment summaries, or the time required to perform any other service that you may request of your therapist.

### **Paying Your Bill**

\_\_\_\_\_ (Parent's Initials) You will be expected to pay for each session at the time it is held, unless agreed to otherwise or unless you have insurance coverage that requires another arrangement. In circumstances of unusual financial hardship, your therapist may be willing to negotiate a fee adjustment or installment plan.

As a courtesy, we will bill your BlueCross/Blue Shield insurance company as we are in-network for BlueCross/BlueShield. We are also able to bill Aetna and ValueOptions for clients with this insurance who are willing to accept their Out-of-Network benefits. **All co-pay fees are collected at the time of each visit.** In the event you have not met your deductible, your full fee is due at each session until the deductible is satisfied. Clients are responsible for all unpaid claims. For all other insurances, full payment is expected at the time of services. The Studio For Change offers a "superbill" (aka resceipt) for clients to submit to their insurance company for reimbursement.

If your account is more than 60 days past due and suitable arrangements for payment have not been agreed to, Studio For Change has the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing these proceedings will be included in the claim.

### **Insurance Reimbursement**

Studio For Change will provide you with whatever assistance your therapist can in facilitating your receipt of your entitled benefits. It is very important that you find out exactly what mental health services your insurance policy covers. In the end, you, and not your insurance company, are responsible for full payment of the fee that we have agreed to. All of our insurance billing is out-serviced through a second party insurance biller and invoices for claims not paid by insurance may be sent directly to clients from our Studio For Change billing office. You should also be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or in rare cases a copy of the entire record.

## **Court/Legal Proceedings and Custody Evaluations**

**\_\_\_\_\_ (Parent's Initials)** If for any reason you become involved in legal action that requires your therapist's participation, you will be expected to pay for the professional time required. Your Studio For Change therapist charges \$250 per hour for any time spent on activities related to legal action. Such time includes all phone calls, fax, emails, face-to-face meetings, transportation time and any additional costs involved in court, arbitration, and other legal preparation. **Unless specifically contracted, your Studio For Change therapist is not acting in the capacity of a custody evaluator and, therefore, is not available to testify for any reason throughout a divorce process.**

## ***Client Records & Confidentiality***

### **Professional Records**

Your Studio For Change therapist is required to keep appropriate records of your work together, such as dates seen and services performed. These records are kept in your main file along with your contact information and are kept in a locked file cabinet. At times, your therapist may record psychotherapy notes from our sessions. Because these records contain information that can be misinterpreted by someone who is not a mental health professional, it is our general policy that clients may not review them.

### **Confidentiality**

**\_\_\_\_\_ (Parent's Initials)** In general, the law protects the confidentiality of all communications between a client and a therapist, and your therapist can only release information about your work to others with your written permission.

However, there are some situations in which your therapist is legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. Specifically, if your therapist believes that your or another child, an elderly person, or a disabled person is being abused, we are required to file a report with the appropriate state agency.

Furthermore, if your therapist believes that your child is threatening serious bodily harm to another, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If you or your child threatens to harm him or herself, your therapist may be required to seek hospitalization and/or additional support from others who can help provide protection. The situations described above occur rarely in our practice. Should such a situation occur, your therapist will make every effort to fully discuss it with you before taking any action.

In most judicial proceedings, you have the right to prevent your therapist from providing information about treatment. However, in some circumstances such as child custody proceedings and proceedings in which one's emotional condition is an important element,

a judge may require your therapist’s testimony if he or she determines that resolution of the issues demands it.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, your therapist will make every effort to avoid revealing your or your child’s identity. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless they feel that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. The laws governing these issues are quite complex. While your therapist is happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your therapist will provide you with relevant portions or summaries of the applicable state laws governing these issues.

To summarize, your verbal communication and clinical records are strictly confidential except for: **a) in a case where a child or elder is being abused or neglected, b) information requested by your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that indicates that you or your child are in danger of harming yourself or others.**

**Acknowledgment of Receipt for Notice of Privacy Practices**

\_\_\_\_\_ (Parent’s Initials) I have read, understand and if desired, received a copy of the Studio For Change’s Health Insurance Portability and Accountability (HIPPA) Notice of Privacy Practices.

***Consent for Treatment***

**Signed Consent to Receive Services**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Child/Teen’s Name (printed) \_\_\_\_\_

Child Signature (13 years or older) \_\_\_\_\_

Parent’s Print Name (printed) \_\_\_\_\_

Parent’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Siblings and Other Adults Participating In Treatment**

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Credit Card On File**

Type of Card (check one):  Visa  MasterCard  Discover

Name on Card (please print) \_\_\_\_\_

Credit Card number \_\_\_\_\_

Expiration Date # \_\_\_\_\_ 3 Digit Code on back \_\_\_\_\_

Card Holder's Billing Address \_\_\_\_\_ Apartment# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

By my signature below, I certify that I understand that this credit card information is to remain on secure file with Studio For Change until the termination of treatment. I authorize all treatment charges, co-payments, unmet deductibles, and late cancellation charges to be billed with this credit card unless I request otherwise.

Signature \_\_\_\_\_ Date \_\_\_\_\_