ALMA COUNSELING CENTER 109 Fairfield Way, Suite 106 A, Bloomingdale, IL 60108

INFORMED CONSENT

Princy Shyam MA., MSW., LCSW for choosing vour counselor. Today's appointment will take approximately 50 to 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. Princy has earned her Masters in Humanities from University of Kerala, India, and Masters in Social Work from Loyola University, Chicago, IL. She is licensed by the State of Illinois as a Licensed Clinical Social Worker. She has a vast clinical experience in treating adults, adolescents, and families using individual and family therapy. Princy practices standard cognitive behavioral therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy and plan limitations and risks will be discussed with you today. CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your communication and clinical records are strictly confidential except:

- (a) for information (diagnosis and dates of service) shared with your insurance company to process your claims.
- (b) for information you and/or your 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.
- (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.
- (f) when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services.

Princy will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s)	Date ·
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FINANCIAL/INSURANCE ISSUES: 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 Princy Shyam.

Signature(s)Date	
PHONE:	
ADDRESS:	
CLINIC:	
PHYSICIAN NAME:	
You may inform my physician(s)I decline to inform my phy	sician
If you prefer to decline consent no information will be shared.	
COORDINATION OF TREAMENT: It is important that all health care work together. As such, we would like your permission to communicate primary care physician and/or psychiatrist. Your consent is valid for one younderstand that you have the right to revoke this authorization, in writing time by sending notice. However, a revocation is not valid to the extent that acted in reliance on such authorization.	with your ear. Please ng, at any
Signature(s)Date	
Lastly, if you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed at the hourly rate. We appreciate your cooperation and at any time you have any questions insurance, fees, balances or payments please feel free to ask. You may ha of this form if requested.	sincerely regarding
I have received a copy of my fee schedule	
owed. We ask that every client authorize payment of medical benefits of Princy Shyam.	lirectly to

and received a copy of the, Notice of Privacy	Practices and Client Rights document.
Signature(s)	Date
May we contact you at home? (Circle one) May we contact you at work? May we contact you by cell phone? Where may we contact you?	Yes No Yes No Yes No
CONSENT FOR TREATMENT OF CHILD I/We consent that a client by Princy Shyam. It is understood confidentiality protected by law. At time appointments during school hours. We ask most timely treatment for you and your child end of treatment or if revoked in writing.	maybe treated as that children over the age of 12 have as it may be necessary to schedule a for your cooperation to provide the
Signature(s)	Date

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I / We have read