CHERRY HILL
COUNSELING

Dear Prospective Client:

Thank you for your interest in Cherry Hill Counseling. We hope your experience with us will be positive.

Enclosed please find some forms, including those listed below, which must be completed, signed and returned to us prior to your visit.

- Client Information
- Credit Card Authorization & Financial Policy
- Insurance Checklist & Verification of Benefits
- Communication with Professional Referrals
- Client Acknowledgment & Informed Consent
- HIPAA Notice of Privacy Practices Acknowledgment of Receipt
- Communication Policy & Consent

If you wish to apply your medical insurance towards any part of your payment, you must complete the Insurance Checklist Form and provide a copy of your insurance card, both front and back. Additionally, enclosed please find your copy of Cherry Hill Counseling's Notice of Privacy Practices for your review and safekeeping.

If you have any questions or concerns, our staff will be available to help. Please contact us at 847-438-4222.

A Preface to Those Who Hate Paperwork:

I hate having to fill out paperwork when I go to yet another doctor, so as the founder of CHC, I want to acknowledge that our packet and forms can be annoying and bothersome to some.

Though I wish we could continue to have a brief document like the one we used in 1976, and following years, times have changed and there are more and more reasons we need to protect your privacy.

So, we apologize for the sizable new client information packet and ask for your patience and cooperation in our efforts to protect you. Thank you.

Sincerely yours,

Clark E. Barshinger, PhD
Director

CLIENT INFORMATION

Which therapist will you be seeing? _____ Date _____

Client Name_____ Date of Birth _____

Gender: M_____ F_____ Marital Status: Married_____ Single_____ Other_____

Address_____ City_____ State_____ Zip Code_____

Phone (H) _____ (C) _____ (W) _____

Email _____ May we leave a message on: Email___(H) Phone___(C) Phone___

Appointment Reminders (choose one): Text___ Cell Phone Carrier _____Email___ (H) Phone___ (C) Phone___

Emergency Contact_____ Phone _____

Name of Parent or Guardian—if client is a minor or dependent _____

Relationship to Client _____ Phone _____

How were you referred to Cherry Hill Counseling? _____

BILLING INFORMATION

Name of Insurance Company _____ Cardholder's Name _____

Employer _____Cardholder's Date of Birth _____ Relationship to Client _____

Insurance ID# _____ Group# _____

**A COPY OF YOUR INSURANCE CARD IS REQUIRED BEFORE ANY CLAIMS CAN BE FILED

If the client is a minor or dependent, please provide the contact information for the person responsible for payments:

Name: _____

Address_____ City_____ State_____ Zip Code_____

Phone (H) _____ (C) _____ (W) _____

Family Physician _____ Physician's Phone _____

Previous Therapy _____

Presenting Problem

_____

_____

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Client Acknowledgement & Informed Consent

CLIENT NAME: _____ **DATE:** _____

Confidentiality

Under state and federal law, matters discussed with your psychotherapist are confidential unless exceptions exist under the law. In most cases, in order to release any information related to your treatment, we will require you to sign a release of information. During therapy, you may request that some information be discussed with another person (i.e., your physician, spouse/partner, children, parents, etc.). If you desire that information be communicated about you to someone else, please ask for a release of information form. If we feel that it will be useful to you, during the therapy process, to discuss your progress or situation with another person (i.e., your physician), you will be asked for your written permission to do so. Please refer to your HIPAA Notice of Privacy Practices for additional information regarding your rights as to the release, use and disclosure of your protected health information.

Please note, the release of confidential information, even without your permission, is required in situations of suspected child abuse, potential harm to oneself or others, and in instances where your records are subpoenaed by proper court order. Please refer to below paragraphs regarding Mandated Reporting and Duty to Warn.

Appointments

Therapy sessions will typically be on a weekly or bi-weekly basis. Additional appointment times can be arranged on an "as needed basis." A therapy "hour" is 45 minutes in duration and may be referred to as a "clinical hour."

Cancellations & Missed Appointments

It is requested that you provide advance notice of cancellation at least 24 hours before your scheduled appointment. If a cancellation has not been made prior to this time, the session is a loss for someone else wishing to use that therapy time. These late cancellations will be billed as a missed appointment at your regular session fee. Remember that most insurance policies do NOT cover missed appointments, so any such charges will be solely the client's responsibility. As such, we require all clients to keep a credit card on file that may be used in the instance an appointment is missed without the required advance notice. Scheduling an appointment means that it will be held only for you and, therefore, cannot be used by another person. If you are late, the session will still end at the normal time.

Children in Waiting Room

We are unable to provide supervision for children in the waiting room and cannot accept responsibility for their safety if left unattended. For the safety and welfare of the children and out of consideration for others, please make other arrangements for childcare during therapy sessions. Parents who do not comply will risk the cancellation of their designated appointment. Parents will be held responsible for any property damage caused by their child.

Telephone Calls

Phone calls may be made at any time for emergencies. No fees are charged for phone calls regarding appointments and similar matters; nor are fees charged for phone calls requiring just a few minutes; however, a pro-rated charge will be made for psychotherapy or psychotherapeutic consultations

conducted over the phone that require more than 5 minutes. This would be billed at the same rate as private face-to-face therapy.

Fees

You will be billed for all time spent with you or on your behalf including, but not limited to, therapists' time spent preparing reports, reading letters and documents, consultations, travel time for "out of office" services, and telephone calls. A list of diagnostic testing fees is available by request. Payment is requested at the time of each session either by cash, check, or credit card.

Insurance Coverage

If you maintain health insurance, part of your therapy expenses may be covered. You must check your policy or call your company. Your therapist will discuss with you insurance coverage, requirements and updates.

In order to pay with insurance, you must complete the Insurance Checklist Form prior to your first visit in order to identify covered services and benefits. If your insurance policy does not cover the necessary services, or you do not receive prior authorization as required by your insurance company, or such authorization has not been timely obtained or has been denied by your insurance carrier, you agree that you will be responsible for the entire payment for services and may be billed as a private/self-pay. Further, you understand that you are responsible for and agree to pay any copayments, deductibles, co-insurance, non-covered services or amounts in excess of your health insurance policy's annual and/or lifetime maximum benefit and understand that any such payment is due at the time of services.

Bounced Checks

A $25.00 charge will be assessed for any check given in payment of your account that is not honored at the bank due to insufficient funds or for any other reason. This fee will be added to your balance due and shown on your statement.

Delinquent Accounts & Collection Matters

Late payments will be subject to a penalty fee of 12%. Delinquent accounts that could not be charged to the credit card on file may be sent to collections if fee payment obligations are not met in a timely manner. If collection efforts are required to resolve your account, you agree to reimburse us the fees for any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorneys' fees.

Ethics & Professional Standards

As psychotherapists and professionals, we work to uphold the most responsible, ethical and professional standards possible, and we are accountable to you. If you have any questions or concerns about your course of contact with us, please feel free to discuss these issues with us. In signing this contract you are agreeing that should you have any dissatisfaction(s) or concern(s) about your treatment, that you will do your best to indicate your concerns to us so we can attempt to address them to your satisfaction. If you are unhappy with your services and need help finding additional or alternate treatment, we will assist you in locating a more suitable referral or therapy resource.

Mandated Reporting

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). Your psychotherapist is a mandated reporter, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the mandated reporter the law absolutely requires that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of this office to first advise the client that the report will be made. Subsequent to a "mandated" report, the client, and possibly others, will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded." The mandated reporter has no choice but to make reports in these situations. The client should be aware that the statute provides for loss of license if a mandated reporter fails to make a mandated report. The statute also provides the mandated reporter with absolute immunity from any criminal or civil liability in the event that such a report is made, even without the consent of the client.

Duty to Warn

Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the psychotherapist may "warn" any intended victim, as well as the responsible authorities, and disclose confidential information, where a client discloses in session that he or she intends to cause serious mental or physical harm to a specifically identifiable victim and presents a clear and imminent risk of harm**.** It is then the psychotherapist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring and/or in order to prevent a serious threat to public safety. Therefore, if a client discloses an intent to harm a specific person, the psychotherapist must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

Caution: Psychotherapy May Be Upsetting

Be hereby forewarned and cautioned that engaging in psychotherapy may involve experiencing uncomfortable past traumatic events and/or difficult intense emotions such as depression, anger, grief, confusion, or anxiety. It may also result in changes in your life that could be difficult to face.

Further, please note, there are no guarantees that psychotherapy or any therapeutic intervention will yield positive or intended results.

Ending Therapy

You can end therapy at any point you wish. Usually therapy pursues specific goals and you and your therapist will discuss together an appropriate termination process. If you decide you want to terminate your treatment, but have a scheduled appointment please be notified you will be billed and held responsible to pay if you fail to call and cancel the appointment at least 24 hours before the scheduled date and time.

Notice of Privacy Practices

I, the undersigned, acknowledge that I have received Cherry Hill Counseling's Notice of Privacy Practices (NPP), and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer as designated on the NPP.

Please ask before signing below if you have any questions about our psychotherapy or our office policies. Your signature indicates that you have read and understand our office policies and agree to enter therapy under these conditions. Further, it indicates your understanding that we may terminate your therapy if you do not comply with the policies or if your therapist feels you are not benefiting from treatment.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECIEPT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE CHERRY HILL COUNSELING NOTICE OF PRIVCY PRACTICES ("NPP"), AND THAT I HAVE READ THE NPP AND UNDERSTAND THE INFORMATION CONTAINED IN THIS NOTICE. FURTHER, I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS NOTICE AT ANY TIME AND IF I HAVE ANY QUESTIONS REGARDING THIS NOTICE, I MAY CONTACT THE PRIVACY OFFICER AS DESIGNATED ON THE NPP.

CLIENT: _____ Date: _____

PARENT/GUARDIAN: _____ Date: _____

61 S. OLD RAND ROAD

LAKE ZURICH, IL 60047

847-438-4222

Fax: 847-438-0844

CHERRY HILL
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INSURANCE CHECKLIST & VERIFICATION OF BENEFITS

Prior to your first visit, you must call the phone number on the back of your insurance card and follow these steps to identify your insurance benefits:

Patient Name: _____
Policy Holder: _____
Primary Insurance: _____

1. Give the Insurance representative the appropriate credentials below:

□ **Clark Barshinger, Ph.D.**	**For Blue Cross Blue Shield use:**	**NPI # 1528135126**
	For all other insurance companies use:	**Tax ID # 26-4357072**
□ **Keith Bjorge, Psy.D.**	**For Blue Cross Blue Shield use:**	**NPI # 1700053360**
	For all other insurance companies use:	**Tax ID # 37-1455185**
□ **Brendan Bell, MA, LCPC**	**For Blue Cross Blue Shield use:**	**NPI # 1003979022**
	For all other insurance companies use:	**Tax ID # 26-1834131**
□ **All Other Cherry Hill Staff**	**For Blue Cross Blue Shield use:**	**NPI # 1225277668**
	For all other insurance companies use:	**Tax ID # 26-4094920**

2. What are my benefits for "in-network outpatient behavioral health"?

Amount of co-pay/co-insurance? _____
How many sessions are allowed? _____
Do I have to satisfy a deductible/how much? _____
Are there 2 separate levels of benefits? Serious & non-serious? _____

3. Do I need pre-authorization before I can be seen by my therapist?

If yes, what is the authorization # _____
Number of sessions approved _____
Name of rep & date of your phone call _____

4. Is my therapist covered under my benefits package?

If "No", what are my "out of network" benefits? _____
_____

5. Insurance company claims address:

_____
_____
_____
_____

Common Procedure Codes:
90791 –Initial Appointment (45)
90834 –Individual Therapy (45)
90837 –Individual Therapy (60)
90847 –Family Therapy (45)

All fields must be filled out prior to your first visit.

INSURANCE AUTHORIZATION

I HEREBY AUTHORIZE payment to be made directly to Cherry Hill Counseling of any insurance benefits covering my care and treatment. I understand, as signee, I am financially responsible to Cherry Hill Counseling for all charges that are not covered by my insurance company. I also give Cherry Hill Counseling permission to release any of my health information obtained during examinations or treatment that may be necessary to support any insurance claims. Further, by signing below, I acknowledge that Cherry Hill Counseling is not responsible for securing authorization or coverage by my insurance carrier for my treatment and services, and I understand that Cherry Hill Counseling cannot be held liable for any limitation of coverage or declined authorization by my insurance policy.

SIGNED: _____ **DATE:** _____

THERAPIST: _____ **DATE:** _____

CREDIT CARD ON FILE AGREEMENT

Please be advised of the following terms of our Financial Policy Agreement:

Outstanding Bills: It is not our policy to carry balances with our clients. Co-Pays are due at the time of service. Unless there is a Financial Hardship Form approved and on file, we will charge co-pays each session and/or charge deductible/co-insurance after Insurance has processed the claim or at month end.

Missed Sessions: Any missed sessions or cancellations without a 24-hour notice will be charged to your designated credit card.

Therapist's Name _____

Client Name: _____

Credit Card Type: ◯ **VISA** ◯ **MasterCard** ◯ **Discover**

Cardholder Name:_____

Billing Address:

_____

_____

Credit Card Number: _____

Expiration Date: _____ **Security Code:** _____

I agree to the terms above and authorize Cherry Hill Counseling to bill my credit card for any unpaid balances due or for any missed appointments.

Signature _____ **Date** _____

COMMUNICATION WITH PROFESSIONAL REFERRALS

If you were referred to Cherry Hill Counseling by another professional (doctor, psychiatrist, school counselor, occupational therapist, police department, etc.), do you give us permission to:

- ☐ Notify the professional that we accepted the referral
- ☐ Consult with this professional in regard to your case

Please note, you will be required to complete our release of information form for us to consult with any professional listed below.

WHO REFERRED YOU: _____ **PHONE:** _____

SIGNED: _____ **DATE:** _____

PARTICIPATION IN OUR MAILING LIST

I would like to receive occasional emails from Cherry Hill Counseling that provide announcements, information about new services, seminars, and promotions. I may elect to stop receiving these emails at any time by simply unsubscribing to the emails.

EMAIL ADDRESS: _____

SIGNED: _____ **DATE:** _____

Cherry Hill Counseling Communications Policy

Contacting Your Therapist

It is important that you be able to communicate with your therapist and also maintain confidential space that is vital to therapy. This outlines the Cherry Hill Counseling Policy for communications. Please be certain to discuss with your therapist your communication preferences and any concerns you may have regarding communication methods.

Refrain from making contact with your therapist using social media messaging systems such as Facebook, Messenger or Twitter. These methods have very poor security and they are not monitored for messages from clients.

When you need to contact your therapist for any reason, the following are the most effective and HIPAA compliant ways to get in touch in a reasonable amount of time:

By business phone at _____ You may leave a secure message.

By secure email through our secure software portal.

Cherry Hill subscribes to *TherapyAppointment* software which provides a secure "client portal" for email communication through the use of encryption and other privacy technologies. There is no cost to you, but you must establish a user account via our website, cherryhillcounseling.com. Check with your therapist to see if online scheduling is an option, as well. If you are an established client, contact your therapist to establish a user name and password for *TherapyAppointment.*

Other Communications Options

You may choose to communicate through other, non-HIPAA compliant forms of communication by reading and completing the Consent for Non-Secure Communications form included in this packet.

Emergencies

Cherry Hill Counseling therapists are not always accessible by phone, nor do they monitor their email 24 hours/day. Further, Text message transmissions are often delayed. If you have an emergency and cannot reach your therapist, call 911 or go to your nearest emergency room.

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Consent for Non-Secure Communications

Please note that non-secured email, iMessage, and SMS messaging are not HIPAA compliant. There are various technicians and administrators who maintain these services and may have access to the content of those communications. Your work or school emails are likely monitored or accessed by others. Additionally, people who have access to your devices may also have access to your email and text messages. Deleting text messages may not actually delete them. Some cell phone carriers keep records of text messages and phone records. Further, some law makers are attempting to pass a Federal law requiring carriers to retain text and phone messages for security and investigation purposes.

Please take a moment to contemplate the risks involved when making decisions about communicating with your therapist through these services.

I have read the Cherry Hill Communications Policy and discussed it with my therapist. I understand the risk in using communication services that are not HIPAA compliant.

I have chosen to communicate with my therapist with the following services as **indicated by my initials below**. I understand I may revoke authorization, in writing, for future communications at any time.

I prefer to communicate with my therapist **only** through secure and HIPAA compliant services.

_____
Initials

OR

I give_____ permission to use non-secured communicate in the following ways:

Email

Appointment notifications, changes, & cancellations only _____
Initials

Communication about anything

_____
Initials

Text Messaging

Appointment notifications, changes, & cancellations only _____
Initials

Communication about anything

_____
Initials

_____ _____
Print Client Name Print Parent/Guardian/Spouse Name

_____ _____
Client Signature Parent/Guardian/Spouse Signature

_____ _____
Therapist Signature Date