Northlight Counseling, LLC
Frequently Asked Questions

Do you treat ALL Issues and problems?

No, Northlight does not provide counseling for the following issues: Homosexuality Support, Sexual Perpetrators, current Drug and Alcohol users and Divorce Mediation. However I can provide counseling services to victims or loved ones of those struggling with these issues, as well as those who have been in successful recovery, and been clean and sober for over 12 months. If necessary, consult your insurance provider for a specialized counselor in your area. In addition, I may be able to refer you to someone I know, who specializes in treating your needs.

How long are the sessions?

Most insurance companies realize that the first session takes longer than the subsequent sessions, to get an accurate diagnosis. Therefore, the first session will probably be about 55-65 minutes, but future sessions will be 45-55 minutes each. Even a 45 minute appointment is often called "an hour session." I respectfully ask for your cooperation in this matter. Please be aware that there may be clients waiting for the next appointment.

How often will we meet? And for how long?

Each situation is different, requiring differing amounts of intervention. This will best be determined upon your first meeting. We typically would meet once a week. If, in a few months, once a week seems to be too much, we will develop a plan that works best for you--perhaps meeting every 2 weeks.

Some issues can take as little as 6 months, while others can take as long as 5 years. Each situation and person is different, and each requires its own time frame. It is difficult to guess how long therapy may take, and a lot depends upon you!

Will you maintain personal privacy and confidentiality?

I give the strictest attention to confidentiality and privacy. I never take it for granted that you have chosen our counseling practice. I will never reveal to anyone that you are a client. I take strict measures to ensure your privacy, such as locked file cabinets, private voice mail service, private email, secure websites, etc.

How much does each session cost?

Northlight Counseling, LLC accepts Aetna, Blue Cross/Blue Shield of Illinois, Cigna, and others. In-network benefits vary per each member's plan, however, a large percentage of the fee is covered (typically 80-100%). Out of Network insurance typically covers 50% of the fee. The initial session fee is $200, and subsequent sessions are $180 each. Fees are not expected to change until January, 2019. If you have no insurance, you must complete the "Low Income" form, and fees must be paid in full before each session, unless other arrangements are made.

What is your therapy approach?
*Thought processes that result in unhealthy beliefs must be challenged and replaced with truth.
*A healthy view of life lines up with God's perspective.
*We can change only ourselves, not others.
*We need to grieve our losses.
*Be real, honest and truthful.
*Learn to get your deepest needs met from God alone.
*Learn good self-care.
*Focus on the positives. Don't dwell on the negatives.
*Optimism can be learned.
*Life is a journey; we must continue to change, grow, move on, and leave the past behind.

What can be done to enhance the success from counseling?
*Be willing to take risks and try new things.
*Value the counseling process. 90% of your success will come about outside the time we spend together, doing the homework, and keeping any and all commitments.
*Be self-motivated and ready to make lasting changes.
*Accept direct and honest feedback.
*Adapt any or all of the information/ideas to make it fit best for you and your situation.

Client Assessment **CLIENT'S NAME:_____ Today's DATE: _____**

Please read the list carefully and mark an **X** next to the problem(s) you are experiencing. **Circle** those statements you feel are the most important at this time.

If the problem sentence repeats, mark it again. If any sentence is not worded the way you want, rewrite it the way you want using the space to the right or below.

Section I

1. My appetite is poor.
2. I am over-eating.
3. I am having difficulty sleeping.
4. I sleep a great deal of the time.
5. My energy level is low.
6. I have difficulty concentrating.
7. I feel hopeless about the future.
8. I am having suicidal thoughts.
9. I have a plan to commit suicide.
10. I feel sad most of the time.
11. I do not enjoy life the way I used to.
12. I feel like a failure.
13. I cry more than usual.
14. I have lost interest in sex.
15. I have lost interest in work.
16. I have lost interest in social activities.
17. I have lost pleasure in things that I once enjoyed.

Section II

1. Sometimes I get out of breath.
2. At times I feel like I'm being smothered.
3. I sometimes feel dizzy.
4. At times I have an unsteady feeling.
5. I experience heart palpitations.
6. Sometimes I find myself trembling or shaking.
7. I break out in a cold sweat for no apparent reason.
8. I experience numbness or tingling sensations.
9. I get hot flushes.
10. I get chest pain or discomfort.
11. I think a lot about dying.
12. I have a fear of going crazy or losing control.
13. I am afraid to drive.
14. I am afraid to leave my house.

Section III

1. I have constant fears that I may do something that will be embarrassing or humiliating.
2. I am afraid to speak in public.
3. I am afraid that I will choke on food when eating in front of others.
4. My hand trembles when writing in the presence of others.
5. I am afraid that I will not be able to talk or answer questions in a social situation.
6. I consistently avoid some situations or activities because of fear of embarrassment.
7. I recognize that my fears are excessive or unreasonable.

Section IV-A

1. I have persistent ideas that I can't get off of my mind.
2. I have recurrent thoughts that make me unhappy.
3. Images repeatedly go through my mind, which are disturbing.
4. I try to ignore or suppress disturbing thoughts, but with little success.
5. I know that the disturbing thoughts I experience are a product of my own mind.

Section IV-B

1. I feel compelled to do things even though they are not logical.
2. I check the locks and windows in the house a number of times before going to bed.
3. I feel that something horrible will happen if I don't check on things.
4. I do things that are excessive or unreasonable, but I can't help it.

Section V

1. Something very disturbing has happened to me. (When: _____)
2. I almost lost my life recently.
3. I was in a serious accident.
4. Someone recently hurt me.
5. I saw someone I care about seriously injured or killed.
6. I cannot help think about what happened to me.
7. I cannot help thing about what I have been through.
8. I have nightmares about what happened.
9. I have difficulty falling asleep.
10. I wake up in the middle of the night or too early in the morning.
11. I sometimes have the sudden feeling that what has happened to me is recurring. I have a sense of re-living the event.
12. When I'm near anything that reminds me of what happened, I get upset.
13. If I see anybody who looks like the person or people who hurt me, I get upset.
14. I try to avoid thinking about what happened to me.
15. I try to avoid activities or situations that remind me of what occurred.
16. I have recently lost interest in a number of significant activities.
17. I cannot remember important aspects of what happened.
18. I am more withdrawn from other people.
19. I feel like my life has changed permanently.
20. I have outbursts of irritability.
21. I have outbursts of anger.
22. I have difficulty concentrating.
23. I feel like I'm always on guard.
24. I startle easily.

Section VI

1. I worry a lot.
2. I'm excessively anxious.
3. I am frequently afraid that something terrible will happen.
4. I worry about money for no good reason.
5. I constantly worry about a possible misfortune to people I care about.
6. I sometimes find myself trembling.
7. I experience uncontrollable twitching.
8. I feel shaky a lot.
9. I have a great deal of muscle tension.
10. I have a lot of aches and pains.

11. I am constantly restless.
12. I tire easily.
13. I suffer from shortness of breath.
14. My heart beats faster than normal.
15. I sweat a lot.
16. I have cold, clammy hands.
17. I experience a sensation of being smothered.
18. I suffer from dry mouth.
19. I get dizzy or light-headed.
20. I have diarrhea on a regular basis.
21. I feel nauseated and have stomach troubles.
22. I frequently have to go to the restroom.
23. I frequently feel keyed up or on edge.
24. I startle easily.
25. I have trouble concentrating.
26. I have trouble falling asleep.
27. I have trouble staying asleep.
28. I have been more irritable lately.

Section VII

Growing up, the kids in my family (**including myself**) in my family's birth order (use back if necessary):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious Background: _____

I would like for Faith to use Prayer, the Bible and Scripture verses in our sessions: _____Yes _____ No

(Circle all that apply.) Were you raised by: Both Parents? Single Parent? Relative? Other?

In your family was there a history of : Alcoholism? Substance Abuse? Mental Illness?

Physical Abuse? Sexual Abuse? Prolonged physical illness? What Kind: _____

_____

Current Medications (any and all) _____

_____

Significant Medical Problems, Surgeries or Medical Procedures (any and all) _____

_____

Have you had previous psychiatric care and/or counseling? Yes No

If yes, give: Name of clinician _____

Sessions from (date): _____ to _____

Have you ever been hospitalized for substance abuse, physical abuse, sexual abuse, alcoholism, eating disorders anxiety, depression, or other mental health issues? Yes No Details (use back if necessary):

Have you ever been convicted of a crime, other than a minor traffic violation? Yes No Details (Use the back if necessary):

CLIENT RIGHTS
(Please keep this page for your records.)

Right to request how we contact you
It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voice mail. You have the right to request that our office communicate with you in a different way.

Right to release your medical records
You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we have acted in reliance on such authorization.

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request to access your billing or health information, contact the office manager. Under limited circumstances we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.
If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or, in some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.
You have the right to request an accounting of disclosures, if any, which is a list of certain disclosures such as child or elder abuse, disclosures related to suicidal or homicidal threats, disclosures to the U.S. Dept. of Health and Human Services to evaluate compliance.

Right to request restrictions on uses and disclosures of your health information.
You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.
If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.
You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Northlight Counseling, LLC has been and will always be totally committed to maintaining clients' confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allows us to use and disclose your health information for these purposes.

TREATMENT We may need to use or disclose health information about you to provide, manage or coordinate your care or related services, which could include consultants and potential referral sources.

PAYMENT Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance and licensing activities.

Other uses or disclosures of your information that do not require your consent: There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others; Information to remind you of/or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

I have read the above thoroughly and understand everything.

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature_____Date:_____

Guardian's Signature: _____Date: _____

Basic Information

Is the client covered by insurance?

_____Yes, the client is covered by insurance.

_____No, the client is not covered by insurance. The client is considered to be "Self Pay," for this amount every session: $_____
(A "Low Income Form" is required for all self-pay clients. Ask Faith for this form, if needed.)

Is the client his/her own Responsible party?

_____Yes, the client is an adult, and is responsible for any payments not covered by insurance.

_____No, the client is not responsible for any payments not covered by insurance. Payments of this type will be the responsibility of a third party, i.e, parent, spouse, relative or guardian.

INSURANCE CARD INFORMATION:

Plan Name: _____

Name of Insured, as it appears on card: _____

Insurance/Member ID: _____

Group ID: _____

Insurance Phone Number for Providers: _____

CLIENT INFORMATION:

Client's First Name: _____Client's Last name: _____

Client's Home Address: _____

City, State, ZIP: _____

(At least ONE phone number is required):

Client's Home Phone, with Area Code:_____

Is it okay to leave a message on the home phone listed above? _____Yes _____No

Client's Cell Phone, with Area Code: _____

Is it okay to leave a message on the Cell phone listed above? _____Yes _____No

Client's Work Phone, with Area Code: _____

Is it okay to leave a message on the work phone listed above? _____Yes _____No

Client's Date of Birth (MM/DD/YY): _____

Gender of Client: _____Female _____Male

Client's Email Address: _____

Is it okay to write to the Email listed above? _____Yes _____No

RESPONSIBLE PARTY INFORMATION:

First name of Responsible party: _____Last Name: _____

Address: _____(SAME AS ABOVE) or; _____

City, State, Zip: _____

(At least ONE phone number is required):

Responsible person's Home Phone, with Area Code:_____

Is it okay to leave a message on the home phone listed above? _____Yes _____No

Responsible Person's Cell Phone, with Area Code: _____

Is it okay to leave a message on the Cell phone listed above? _____Yes _____No

Responsible Person's Work Phone, with Area Code: _____

Email Address: _____

Is it okay to write to the Email listed above? _____Yes _____No

Responsible Person's Date of Birth (MM/DD/YY): _____

Gender of Responsible Person: _____Female _____Male

EMPLOYMENT INFORMATION:

Responsible Person's Employer's (Company) Name: _____

Responsible Person's Employer's (Company) Address: _____

Responsible Person's Employer's City, State, ZIP: _____

Is there any other Health Benefit Plan for the Client? _____

If so, please give Other Insured's full Name: _____

Other Insured's Date of Birth: _____Other Insured's Gender: _____

Other Insured's Health Plan Benefit Name: _____

Other Insured's Policy or Group number: _____

Other Insured's Employer Name: _____

INFORMED CONSENT

Thank you choosing Northlight Counseling, LLC. All appointments will take approximately 45 – 50 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims/verify treatment or information necessary to collect payment; b) information you and/or you child or children report, (or if I even suspect any) physical or sexual abuse; then, by Illinois State Law, as a Mandated Reporter I am obligated to report this to the Department of Children and Family Services (*see below); c) where you sign a release of information to have specific information shared; e) if you provide information that informs me that you are in danger of harming yourself or others; f) as outlined in the HIPAA Notice of Privacy Practices; g) if I hear of or suspect any elderly abuse, I need to contact the Department on Aging, as required by Illinois State Law, as a Mandated Reporter. I only maintain clinical records and do not keep psychotherapy notes. 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 for those services. Jaril Faith Gallup, LCSW will follow those emergency services with standard outpatient counseling and support to the client or the client's family. Any threat to your, or another person's, well being requires me to proceed with involuntary hospitalization procedures, for a suicide threat, or warn the person, for a homicide threat, under the ethical guideline called "duty to warn." Duty to Warn Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the psychotherapist must "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 (police) 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.*
***DCFS: 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). If abuse or neglect is suspected 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.*

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature_____Date:_____

Guardian's Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: *I/We have read, and/or received a copy of, the HIPAA Notice of Privacy Practices and Client Rights document.*

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature_____Date:_____

Guardian's Signature: _____Date: _____

COURT INFORMATION: I/We, the undersigned, understand that Jaril Faith Gallup, LCSW does NOT typically attend any court dates, nor provide any therapy notes and/or progress notes, for the court, for any reason. If a court order is sent to J. Faith Gallup, LCSW, requiring any progress notes, therapist's notes, statements, or letters, a $500 fee will be incurred, and will be immediately charged to the above credit card. Appearance in court is $800, for each appearance, for any reason, including failure to pay fees. *If fees are not paid in full to provider, legal proceedings will begin, and you will be charged for all attorney's fees, court fees, gasoline used, depreciation of vehicle, mileage on vehicle, at the rate of $0.56 per mile, or the maximum allowed by law (to and from post office, attorney's office and court), ink and printer fees, all postal fees and all other fees incurred including $100/Hour time spent on pursuing fees due. Your refusal to provide accurate credit card number, expiration date, CVV code, or signature will result in my refusal to provide counseling services to you.* I/We completely understand these fees, and agree to all the conditions stated.

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature_____Date:_____

Guardian's Signature: _____Date: _____

CONSENT FOR TREATMENT OF CHILDREN: *I/We consent(s) that*

(Printed Name of Client):_____ may be treated as a client by Jaril Faith Gallup, LCSW, for mental health therapy.

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature_____Date:_____

_____Date_____
Signature of Parent or Guardian

_____Date_____
Signature of Parent or Guardian

SEPARATION OR DIVORCE PENDING: *If there is a legal separation, a divorce pending, or a finalized divorce, you understand that you need to disclose a copy of the Separation Decree or Divorce Decree, including the Custody Stipulations to Jaril Faith Gallup, MSW, LCSW. By signing this agreement, you understand that you will forward a copy to Northlight Counseling, LLC, 5101 Washington, Suite #1102, Gurnee, IL 60031, as soon as possible, and needs to be done before the next session.*

_____Date_____
Signature of Parent or Guardian

NO CUSTODY ISSUES: *I, the undersigned, do testify under penalty of law, that there is no Custody pending, finalized or authorized. If there is a change in the current Custody arrangements, I understand that ALL persons sharing custody need to agree to Mental Health Services for the patient who is a minor. If I knowingly allow consent for treatment without the permission of the other parent, I take full responsibility and assume all risks involved for the financial, emotional, and any other responsibilities and outcomes of this action. I promise to not include Jaril Faith Gallup in any dispute or legal actions, due to the negative response of the other parent.*

_____Date_____
Signature of Parent or Guardian

CHILDREN IN THE WAITING ROOM: *Jaril Faith Gallup, LCSW is 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. By signing this agreement, you agree to take full responsibility and assume all risks involving the financial, emotional and psychological outcomes.*

_____Date_____
Signature of Parent or Guardian

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.*

TELEPHONE, TEXT, AND EMAIL COMMUNICATION: *I may be contacted by phone or text (847-962-5234) and email (FaithGallup77@gmail.com) with the understanding that email is intended for non-urgent, general and administrative purposes since complete confidentiality cannot be ensured by this means of communication. Phone calls can last no longer than 5-10 minutes. Also, please be aware that any text message, email, or other written correspondence that I receive from you becomes a part of your clinical record. Due to the nature of my work, I am often not immediately available by phone or email. I monitor my voicemail and text messages frequently and will make every effort*

to return your call or email within 48 hours with the exception of weekends, holidays, and scheduled vacations. I do not provide emergency services within my practice. A crisis resource for 24/7 mental health support is 1-800-LIFENET (1-800-543-3638). In the event of a life or limb-threatening emergency, always call 911 or go to the nearest emergency room.

SOCIAL MEDIA: *As policy, I will not accept friend and contact requests from current or former clients on any social networking sites such as Facebook, LinkedIn, etc. I will also not follow any current or past clients on any social media sites such as Twitter, Instagram, blogs, etc. Connecting to clients on these sites can compromise confidentiality and also our therapeutic relationship. If there is content you wish to share with me from your online presence, we can explore it together during your session. I have a Twitter account for which I use for professional purposes such as sharing psychology-related information. I have absolutely no expectation that my clients will follow my Twitter stream or any blog/article that I may publish. If I happen to notice that you are following me on Twitter, etc., I may bring this up during a session to discuss any impact that it may have on our therapeutic relationship.*

OUT OF NETWORK: *If I am an out-of-network treatment provider for your insurance, I can provide you with the necessary receipts and other documentation you need in order receive reimbursement through your out-of-network benefits. Most insurance plans offer out-of-network benefits for mental health treatment, but it is necessary that you contact your insurance company to determine exactly what coverage you are entitled to through your specific insurance policy including information about your deductible. Be advised that you (not your insurance company) are directly responsible for the full amount of all fees associated with my services at the beginning of each session ($200 for initial session, and $180 for subsequent sessions) and later you will be reimbursed by the insurance company for any covered expenses. By signing this Treatment Agreement, you are acknowledging that you are responsible for the full payment of our agreed upon fee-for-service. If you wish to receive reimbursement for psychotherapy services through your insurance company, I am required to provide information relevant to the services I provide you. I will make every effort to only release the minimum information about you that is necessary for the purposes requested. Please be aware that although insurance companies claim to keep your protected health information (PHI) confidential, I do not have control over how they will store or use your information. By signing this Treatment Agreement, you are acknowledging that I can provide the required information to your insurance carrier.*

FINANCIAL/INSURANCE ISSUES: *As a courtesy, I will bill your insurance company, responsible party or third party payer for you, if you wish. I ask that at each session you pay your co-pay, depending on your insurance policy. If your insurance company denies payment or does not cover counseling, it is my policy that you will pay the balance due, unless usual and customary fees agreement has been made, as an in-network provider. It is your responsibility to pursue payment from your insurance company, and if they do not correctly process the benefits, you may pursue the situation with your insurance company. Statements are sent out the first week of the month, and the full amount is due upon receipt. Checks that are returned for insufficient funds are subject to a fine of $30.00, or the maximum allowed by law. I ask that every client authorize payment of medical benefits directly to Jaril Faith Gallup, LCSW. The initial fee is $200.00 and subsequent sessions are $180.00, unless other arrangements are made. Payment by credit card is available by Pay-Pal, at* www.northlightcounseling.com*, and in the office, using SwipeSimple. Your credit card number will be on file (below), and will be processed only in the event of unpaid statements, or if the balance due at any time is more than $30, or if you choose to make all co-pays, fees, and payments for statements on them. (Prices are subject to change without notice, however, the next fee change is not due until January, 2019). If fees are not paid in full to provider, legal proceedings will begin, and you will be charged for all attorney's fees, court fees, gasoline used, depreciation of vehicle, mileage on vehicle, at the rate of $0.535 per mile, or the maximum allowed by law (to and from post office, attorney's office and court), ink and printer fees, all postal fees and all other fees incurred including $100/Hour time spent on pursuing fees due. If you have no insurance, please complete the "Low Income Form," and provide credit card information there. Your refusal to provide accurate credit card number, expiration date, CVV code, or signature will result in my refusal to provide counseling services to you.*

Lastly, please be aware that any and every appointment is considered a "Set Appointment," whether it is made by phone, email, in writing, online, or in person. You will NOT receive a reminder phone call for set appointments. If you need to cancel or reschedule an appointment, you must give 24 hours notice, otherwise a charge of $100.00 will be charged to your account. Insurance companies cannot and will not pay the charge for a canceled appointment.

Credit Card type: (Circle One) MasterCard Visa Health Savings Account Discover

PRINT name exactly as it appears on the card: _____

Billing Address for this card: _____

City, State and ZIP of billing address for this card: _____

Credit Card Number: _____

Expiration Date: _____CVV Security Code (on back of card): _____

****I choose to pay all my co-pays, fees, and statements via the credit card number above: ___Yes ___No**

I/We, the undersigned, have read the above very carefully, and fully understand the financial requirements and, if not followed, the maximum consequences allowed by law, and I/we agree to all of them.

Signature(s) of Adult Cardholder(s)_____Date_____

NOTIFICATION TO PATIENT REGARDING
CONFERING WITH PRIMARY CARE PHYSICIAN

Pursuant to Illinois law, you are hereby informed that it is desirable that I confer with your Primary Care Physician. I am required to notify him or her that you are seeking and/or receiving mental health treatment unless you waive such notification.

Please initial one of the following:

_____ I agree to allow Jaril Faith Gallup to notify my Primary Care Physician that I am seeking and/or receiving mental health services and communicate as deemed clinically necessary with said physician.

_____ I WAIVE NOTIFICATION of my Primary Care Physician that I am seeking and/or receiving mental health services, and I direct you NOT to so notify him or her.

_____ I do not have a Primary Care Physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking and/or receiving mental health services.

NAME (print): _____

If client is between 13-18 years old, client and guardian must sign and date, showing understanding of the above:

Client's Signature: _____Date of Signature: _____

Guardian's Signature: _____Date of Signature: _____

(If granting permission, please complete the following.)

Client's Primary Care Physician is: _____

Address: _____

City, State, ZIP: _____

Phone (Area Code First): _____

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