NAPERVILLE
CLINICAL ASSOCIATES

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PATIENT INFORMATION BROCHURE

Welcome to my psychotherapy practice. This document contains information regarding my practice to help you understand the policies as well as to achieve the best therapy outcome. If you have any questions or concerns after reading this brochure, please feel free to ask questions.

Psychotherapeutic treatment: Participating in psychotherapeutic treatment is a collaborative process between the client and the psychotherapist. Psychotherapy may result in a number of benefits to you, including improving interpersonal relationships and resolution of part or all of the concerns that led you to seek therapy. Psychotherapy may also help facilitate positive growth and development. Working toward these benefits requires effort on part of the patient. Psychotherapy requires your involvement, honesty and openness in order to change thoughts, feelings and/or behavior. During treatment, remembering or talking about unpleasant events, feelings or thoughts can result in considerable discomfort or strong feelings. Together, we can address the discomfort or strong feelings that arise during the course of treatment. Psychotherapy is a process of discovering what will work for each individual patient. Change will sometimes be easy and swift and/or it may be difficult and slow.

During the course of therapy, I will likely utilize various therapeutic approaches to deal with problems or concerns you, the patient or the parent/guardian of the patient, hope to address. The therapeutic approach used will depend on the presenting issue, evidence-based research/practices and my professional judgment. If you have any questions about the therapeutic approach used in the course of treatment, you should not hesitate to ask. If I conclude that the patient could benefit from other treatment methodologies that I do not provide, I will refer the patient and/or-family to another professional. I do not take on patients that I do not think I can help. Therefore, I enter our relationship with optimism. If, at any point during treatment, I assess that as the therapist I am not effective in helping the patient, the patient will be referred on to another professional and treatment will be terminated.

Office Hours: I offer evening appointments. Patients who need to speak with me can leave a message on my confidential voicemail at the number listed above. I check messages on a regular basis. Most calls are returned within 24 hours, except weekends/holidays. Voicemail messages left over the weekend will be returned the following week.

Emergency Contact: The services I provide are offered in the form of regularly scheduled visits of a nonemergency nature. Please be aware that my office is not set up to provide emergency services. If a mental health emergency arises, please contact to go to the nearest hospital emergency room, or contact the DuPage County Crisis Center (630) 627-1700. For emergencies in Kane County, residents may call the Ecker Center (847) 888-2211.

Insurance Coverages: Typically, your health insurance policy will provide some coverage for mental health treatment; however, you are ultimately responsible for full payment of my fees. Since the insurance contract is an agreement between you and your insurance carrier, it is very important that you call your insurance company to find out what mental health services your insurance policy covers. If applicable, authorizations for service must be obtained by the patient prior to the office visit.

Those patients who use out of network insurance will need to provide payment for the full fee at each appointment. Clients selecting to self-pay are asked to keep their accounts current and to pay for each session on that day. Visa, MasterCard, Discover, American Express and cash or checks are acceptable forms of payment. Self-pay clients will receive a superbill that contains all of the codes necessary for obtaining insurance reimbursement.

Delinquent Account: Accounts with no payment activity or those with a previous arrangement that are not being adhered to will be considered past due after 60 days and may be referred to an outside agency for collection. All costs associated with this action will be the responsibility of the patient. Accounts with balances past 90 days will be subjected to a finance charge of 1.5% per month. Patients with delinquent bills may also be dismissed from my practice.

Failed Appointment/Late Cancellation Policy: Appointments must be canceled or changed by 9:00 a.m. on the previous business day or you will be charged the full fee ($130.00 for individual or $150.00 for family or couple) for the session. Monday appointments must be canceled by Friday at 9:00 a.m. Arrivals of more than 15 minutes late will need to be rescheduled and you will be charged for the full fee. Any charges applied Must be paid prior to your next visit. These charges are not billable to your insurance company.

Confidentiality: In general, the law protects the privacy of all communication between the patient and a mental health provider. I can only release information about our work to others with your written authorization. Furthermore, I can neither confirm nor deny that a patient is being seen in my practice without your written authorization. This includes all family members. Please be advised that questions regarding your billing matters will be discussed with only the patient or guardian.

There are a few exceptions in which the law requires that confidentiality is waived. If a patient informs me that there is any possibility of harm to self or others, including, but not limited to physical or sexual abuse, neglect, and suicidal or homicidal behaviors, the law requires that I make a formal report regarding the situation. If the need to make a report arises, I will make every effort to involve you in the process and do so with your participation.

In addition, patients need to be aware that most insurance companies require me to provide them with a clinical diagnosis. In addition, I may be required to share case notes, treatment plans or treatment summaries in order for your insurance company to process the claim. Whenever possible, I limit the information and provide the least amount of information required for the insurance company to process the claim. If your insurance company requests additional information from me, I will discuss this with you. If you agree to release the information to your insurance company, I will have you sign a consent to release information.

Child Therapy: It is my policy to provide you with general information about treatment status. I will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, I will share that information with you. I will not share with you what your child has shared with me without your child's consent. I will tell you if your child does not attend sessions.

Although my responsibility to your child may require my involvement in conflict between the two parents/guardians, I need your agreement that my involvement will be strictly limited to that which will benefit your child. This means, among other things, that parents/guardians will treat anything that is said in session with me as confidential. Neither of the parents/guardians will attempt to gain advantage in any legal proceeding between the parents/guardians from my involvement with your child. In particular, I need your agreement that in any such proceedings, neither parent/guardian will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent's/guardian's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at a rate per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs. That rate will be discussed, if necessary. Finally, if I am requested to attend a school staffing or to provide a report to the school, the responsible party for my participation agrees to reimburse me at a rate per hour for time spent traveling, preparing reports, being in attendance, and any other related costs. That rate will be discussed, if necessary.

Consultation: Licensed Clinical Professional Counselors consult with other highly qualified professionals regarding their patients at times. Patient's names and other identifying information are never mentioned without patient consent. Confidentiality is fully maintained.

(More)

Signature: I, _____ (the patient and/or parent/guardian), have read and understood this Patient Information Brochure. I have received and reviewed the Notice of Privacy Practices. I have discussed with my therapist those points I did not understand and have had my questions, if any, addressed. I agree to abide by the terms of this brochure during- my treatment. I hereby agree to enter into psychotherapy with this Licensed Clinical Professional Counselor, Jodette Wheat, L.C.P.C., and to cooperate fully and to the best of my ability as shown by my signature below.

_____ _____

Patient Signature (12 years old or older) Date

_____ _____

Parent/Guardian Signature Date

Clinician to sign at first visit: I have discussed with my patient and/or patient's parent/guardian the policies and procedures described in this Patient Information Brochure, including the patient's responsibilities, their rights to privacy, exceptions to confidentiality, and the potential risks and benefits of psychotherapy.

_____ _____

Jodette Wheat, L.C.P.C. Licensed Clinical Professional Counselor Date