Julie Johnson, MA, LCPC **2656 W. Montrose Ave Suite 105 Chicago, IL 60618**
Licensed Clinical Professional Counselor **773-383-7033 www.juliejohnsonlcpc.com**

Statement of Understanding/Informed Consent

Welcome. This information is intended to help you feel as comfortable as possible as you begin psychotherapy. It contains information about my services and summary information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protection and patient rights with regard to the use and disclosure of Protected Health Information (PHI).

As with any treatment, there are some risks as well as benefits with therapy. Risks sometimes include experiencing uncomfortable or painful feelings such as sadness, anxiety, anger, frustration or other feelings. These risks are normal and to be expected when people are making important changes in their life. While you consider these risks, you should also know that therapy has been shown to have many benefits that include significant reduction of distress as well as improved relationships and coping skills, increased self awareness and happiness.

Session format:
Psychotherapy typically involves weekly sessions. The standard session length is 45 to 50 minutes. Our sessions will usually occur at the same time and day each week.

Appointments and Cancellations:
If you need to cancel an appointment, please notify me at least twenty four (24) hours in advance of your appointment time. If you DO NOT provide 24 hours notice of a cancellation, or you miss or fail to show up for your appointment, you will be charged the full amount for the session. Insurance will not pay for missed or cancelled appointments. You will be charged and personally responsible for the payment if you do not give (24) hour notice.

Confidentiality and limits on confidentiality:
In all but a few rare situations, your confidentiality is protected by state law and by the rules of my profession. Information you share with me and all matters relating to your psychotherapy will be kept strictly confidential and will not be disclosed without your written permission to release information to a specific individual or organization. However, if you are in imminent danger of harming yourself or others or in any situation in which a child or elderly person is being abused, physically, sexually or by neglect, I am required by law to report that danger. In such a situation, I would talk with you about this and the action that will need to be taken if feasible.

Phone and Emergency Contact:
I do not provide emergency services, if you are experiencing an emergency, please call 911 or go to the nearest hospital emergency room. I am available by phone for follow up or check in or schedule/cancel an appointment. At the time of your call, if I am not available, you can leave me a message and I will call you back within 24 hours.

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Fees, Payment, Billing and insurance reimbursement:
You are expected to pay for services at each session. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount as estimated by your insurance quote of benefits. If actual payment by your insurer differs from what was expected, a financial adjustment will be made promptly. Currently, the acceptable forms of payment are cash, check, or credit card payable to Julie Johnson, MA, LCPC.

1. If you choose not to use insurance for psychotherapy services or if you are covered under a plan for which I am not an in-network provider, or if you are not insured, you will be expected to pay the full fee for each session. In some situations, a reduced rate/fee is available.
2. If you choose to use your insurance and I am an in-network provider in your plan, you will be expected to pay your deductible, co-pay, or coinsurance based on the mental health provisions of your insurance plan. Also, most insurance companies require me to provide a clinical diagnosis and sometimes other clinical information such as treatment plan or summary when submitting claims for payment of therapy services.

I/We _____hereby give permission for Julie Johnson, MA, LCPC to bill my/our insurance company for mental health services/treatment.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

I/We _____authorize payment to be made directly to Julie Johnson, MA, LCPC by my/our insurance company.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

_____ _____
Julie Johnson, MA, LCPC Date

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I/We_____agree to NOT use my/our insurance or that I/we don't have insurance and agree to pay Julie Johnson, MA, LCPC full fee or reduced fee that was agreed upon.

_____ _____
Client Signature Date

_____ _____
Client Signature Date

My/our signature below indicates that I/We have read this agreement and agree to its terms and also serves as an acknowledgement that I/we have received the HIPPAA notice form described above.

_____ _____
Client Signature Date

_____ _____
Client Signature Date