PATIENT INFORMATION SHEET

Before your initial visit please complete the Client Intake form, this Patient Information form, the consent to treatment form and read and sign acknowledgement of the HIPAA regulations form. Please scan completed forms to debraalper1@gmail.com.

APPOINTMENTS

Appointments will be scheduled at a time acceptable to both the patient and the therapist and last 53 minutes. Typically, clients are seen once a week. All sessions are telehealth.

FEES
Federal Truth in Lending Disclosure Statement for Professional Services

Part One - Fees for Professional Services

I (we) agree to pay Debra Alper, LCSW of Life Transitions Counseling, PLLC, a rate of $225/clinical unit (defined as 53 minutes session) for counseling. Payment is due at the time of the session by Zelle.

Part Two - Cancellation Policy

There is a 48-hours' notice cancellation policy. If you cancel a scheduled appointment with less than 48-hour notice, you will be charged a $225 cancelation fee. Our scheduled time is reserved exclusively for you, and if cancelled with less than 48 hours' notice, the time is lost. All of us have unexpected situations and emergencies that come up in life, so it is important that I enforce this policy, regardless of exception, for all my clients.

Part Three - Clients using Medical Insurance

I am in network with BCBSIL PPO. All co-pays and co-insurance payments are due at the end of every session. Any late cancelled sessions or missed sessions cannot be submitted to insurance and the client will be responsible for payment directly to me of my full fee of $225 before our next scheduled appointment. If I am not a part of your insurance network and you want to submit out of network receipts, I will provide you with a monthly statement that contains all the relevant information about the session, dates of service, charge and amount paid and your diagnosis and treatment codes. You will then be able to submit the statement to your insurance company for reimbursement directly to you. Any lapse of coverage or rejection of coverage that does not cover client's session for whatever reason will be billed at my current self-pay rate and will be the client's responsibility to pay.

I HEREBY CERTIFY that I have read and agree to the conditions and have read the Federal Truth in Lending Disclosure Statement for Professional Services.

I HAVE READ THIS PATIENT INFORMATION SHEET AND UNDERSTAND THE REQUIREMENTS AND RULES OF THIS OFFICE. I AGREE TO THE TERMS THEREIN AND GIVE MY CONSENT TO THE EVALUATION / TREATMENT PROCESS WITH Debra Alper, LCSW

Person responsible for account: _____ **Date:** _____/_____/_____