Amy J Gartner, LCSW, Inc.
360 Memorial Drive
Suite 160
Crystal Lake, Illinois 60014

(815) 307-6056

Contact Information:

Name Date of Birth

Address

Email

Cell phone

Is is ok to leave a message at this number?

Responsible Party:

Name Relationship to client

Address

Cell phone

How did you hear about me?

Amy J Gartner, LCSW, Inc
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I ____________________________, acknowledge that I received a copy of the Notice of Privacy Practices for Amy J. Gartner, LCSW, Inc.

Signature of Client_____________________________________Date____________

Amy J Gartner, LCSW, Inc.
360 Memorial Drive
Suite 160
Crystal Lake, Illinois 60014

(815) 307-6056

Financial Agreement:

You will be expected to pay for each session at the time it is held, unless we agree otherwise or you have insurance coverage which requires another arrangement. You will always be expected to pay the insurance co-pay at the time of service.

My rate is $200 for the initial session and $150 for each additional session. Sessions are 60 minutes in length. You are responsible for ascertaining your limits with your insurance company.

Returned checks will be charged a $40 fee for insufficient funds.

Appointments not cancelled 24 hours in advance, will be billed to you.

In the event that I bill your insurance company and they do not pay, you will be responsible for payment in full.

If I am not a participating provider on your insurance plan, I will provide you with a billing statement at the end of the session that you can file with your insurance company. I will expect you to pay me at the time of service and file with your insurance company at your convenience.

I do not testify in court cases. I do not provide any records, progress notes or diagnostic evaluations for legal cases of any kind. Your signature below acknowledges that you understand this statement.

Confidentiality:

Counseling services are confidential. I will use and protect your information in compliance with applicable state and federal laws. Information obtained in counseling sessions will not be disclosed to anyone without your knowledge and written consent. **With the following exceptions:**

1. If I believe that you present an imminent, serious risk of injury or death to yourself or someone else, I will disclose to the parties that I believe can keep you safe.

2. If I have a reasonable cause to believe that a child, elderly person, or disabled person is being abused, neglected or financially exploited, I am required by law to report this to the authorities.

3. If I am a provider for your insurance company, they **will** ask for and I am required to provide them with:

   Diagnosis
   My fee
   Dates that we meet
   Treatment Plan
   Summary of Treatment

Signature____

Print Name____

Date____