**Bethany Mitchell, M.A., LCPC**

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**Psychotherapy Information Disclosure Statement:** Therapy is a relationship that involves clearly defined rights and responsibilities for each person involved. This frame helps to create safety and to clarify the goals, benefits and limitations of therapy. As a client in therapy, you have the right to be informed of these benefits and limitations.

**Telephone:** During my time in the office, I am generally in session and cannot be disturbed. You can leave a confidential voicemail, and I will get back to you at my earliest convenience.

**Email and Text Messaging:** All electronic communication will be limited to scheduling or logistical information. Extensive details regarding your personal and therapeutic concerns will occur in person during the therapy session. Emails that contain anything more than scheduling information will be saved for discussion at the next scheduled appointment. This measure is taken as a practical concern and also to help protect your privacy. Please note that any emails or text messages you send will be protected to the best of my ability, but I cannot ensure 100% confidentiality. This limitation extends to any online or phone conversations.

**Emergency:** In the case of a life threatening emergency, please dial 911 or go to your nearest emergency room.

**Fees:** My fee is $150 for a 50-55 minute session and is due at the time of each session. If you are late for your appointment, it is typically necessary to stop at the normal time.

**Cancelations:** If you need to cancel or reschedule a session, please provide 24-hour notice (except in cases of emergency or unexpected illness). I will allow one misses session without charging a cancellation fee. However, if a second session is missed without notice, and is not an emergency, a $50 cancellation fee will be applied.

**Insurance:** If you have a medical policy that covers counseling, I will give you a receipt containing the necessary information for your insurance company. Send the receipt in with a copy of your medical card, and they will reimburse you directly. If you have Blue Cross Blue Shield of IL-PPO, I will collect payment for services from your insurance company in most cases (check with your insurance company for details). You will be responsible for your own deductible and co-payment. IF fee you expect your insurance company to cover are rejected for any reason, these fees remain the client’s responsibility to pay. If you intend to collect from your insurance company, please know that you waive your confidentiality. Insurance reimbursement requires a disclosure of your presenting problem, diagnosis, and treatment program.

**Termination:** When you are ready to leave counseling, please give me a week’s notice so that we can summarize the work that you have done here and provide a sense of closure

**Confidentiality:** I understand that any and all information communicated in sessions will be held in strictest confidence. None of what is said or done will be divulged verbally or in writing without my written permission. I understand that exceptions are made when child or elder abuse is involved or when the client is a danger to self, others or is unable to care for self. In these cases the appropriate person or agencies will be notified. I also release information that my insurance carrier may require for reimbursement. If my therapist deems consultation necessary to my treatment, she is permitted to confer with another professional.

**Client Consent to Therapy:** I have read and understand this consent to participate in therapy, to the use of a diagnosis for billing purposes, and to the release of information necessary to complete the billing process. I agree to pay any co-payment required by my health insurance company for each therapy session I attend, and understand I am responsible for any charges that my insurance company will not cover. I agree to participate in therapy with Bethany Mitchell, MA, LCPC and understand that I can refuse any suggestions made by Bethany and/or end my participation in therapy at any time.

I understand and/or agree to the above guidelines.

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