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INFORMED CONSENT

Thank you for choosing Felice Block for your counseling needs. Today's appointment will take approximately 60 minutes for an individual session and up to 90 minutes for a family or couple session. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and I will try my best to give you all the information you need. I am licensed in the state of Illinois as a clinical professional counselor and earned a Bachelor of Science Degree in Special Education and a Masters Degree in counseling psychology from the Adler Institute, now Adler School of Professional Psychology in 1985. I received postgraduate training in marriage and family therapy; I am a clinical member of the American Association for Marriage and Family Therapists. I am an adjunct professor at the Adler School of Professional Psychology. Techniques used in my practice come from an integration of many models of therapy including, cognitive behavioral therapy, Adlerian and family systems, existential, gestalt therapies as well as Eye Movement Desensitization and Reprocessing (EMDR.) EMDR is a treatment approach that has been widely validated by research in the treatment of Post Traumatic Disorder. There are a number of studies in progress that research EMDR's effectiveness with other disorders such as anxiety, panic, phobias, obsessive compulsive disorders or depression.

LIMITATIONS OF TREATMENT: *There are no guarantees for successful outcome of treatment. However, there are factors which improve the likelihood of success. These factors include regular attendance to scheduled appointments, investing thought, time and effort in between sessions, following recommendations including homework assignments or reading material. The process of counseling can bring up uncomfortable feelings that may impact you and/or your family or loved ones. Discuss these feelings and issues during your treatment. **If you feel at any time you wish to discontinue treatment, please plan on attending at least one terminating session. This procedure is in the best interest of the client to reinforce gains made in treatment, prevent relapse and/or to make any further recommendations.***

I am committed to provide the highest level of care by keeping abreast with the latest techniques and clinical strategies through continued education and collaboration with clinical supervisors and colleagues.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communication and clinical records are strictly confidential except for: a) information shared with clinical consultants for case supervision b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this*

to the Department of Children and Family Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or other, e) I am also mandated by the state to report elder abuse. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. I am not available for 24 hr. crisis intervention, but will make every effort to return your non-emergency calls within 48 hours.

During the course of the work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple, unless otherwise indicated. If you are involved in one or more of such sessions, please understand that generally these sessions are confidential in the sense that I will not release any confidential information to a third party unless required by law to do so or unless I have your written authorization. However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit – that is, the family or the couple if I am to effectively serve the family unit being treated. I will use my best judgment as to whether, when, and to what extent that I will make disclosures to other members of the family treatment unit, and will also, if appropriate, first give the smaller part of the treatment unit being seen the opportunity to make the disclosure. This “no secrets” policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interests to arise where an individual’s interests may not be consistent with the interests of the family unit being treated. If appropriate, you may be asked to sign a separate document pertaining to my “NO SECRETS” policy. My signature below indicates I have read this confidentiality policy and understand potential limitations to confidentiality.

Signature(s) _____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

FINANCIAL/INSURANCE ISSUES: *Payment is due at time of service. I accept cash and checks with photo identification. A receipt will be provided for insurance or flex account reimbursement. Insurance is a contract between you and the insurance company. I will assist you in obtaining information regarding your policy, but ultimately you are responsible for specific knowledge regarding requirements and stipulations of your policy. Not all insurance plans pay the same benefits or apply the same deductible amounts. There may be a balance due that you will be responsible for after your insurance company has paid us. If your insurance company does not respond within 30 days (as required by law), you will be liable for the charges. It is essential that the Guarantor provides us with the correct information for filing claims and to notify us of any changes in insurance or other information necessary for claims processing. If you fail to notify me, the claims could be denied and you will be responsible for all charges. We realize that temporary financial problems may affect timely payment of your account. After the Explanation of Benefits (EOB) has been received from your insurance company and posted to the account, any amount due from you and not paid 60 days following will be referred to a collection agency. In the event that an account is overdue and turned over to a collection agency, the client or responsible party will be held responsible for any collection fee charged to my office to collect the debt owed. There will be a \$50.00 service charge for any returned checks.*

By signing below, I understand insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents

Lastly, I understand if I need to cancel or reschedule an appointment, **24 hours** advance notice is required. In the event the cancellation is made less than 24 hours or in the event I miss an appointment without notification, I will be **billed at the undiscounted hourly rate of \$140.00 for 45 minute individual sessions and \$160.00 for 45 minute couple & family sessions.**

Signature(s) _____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

____ You may inform my physician(s) ____ I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

Signature(s) _____

Date _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s) _____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

May I contact you at home (circle one) **yes no?** May I contact you at work **yes no?** May I contact you by cell phone, **yes no?** May I contact you via email, **yes no?** If yes, what email address may I use? _____

Would you like to be notified about special programs, articles or newsletters via email **yes no?**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ may be treated by Felice Block, M.A., LCPC as a client. At times it maybe necessary to schedule appointments during school hours. I ask for your cooperation to provide the timeliest treatment for you and your children.

Signature(s) _____ Date _____

_____ Date _____

_____ Date _____