Lynn S. Denton, LCSW

2530 Crawford Ave. Suite 312 Evanston, IL 60201

847-372-1277 ldenton847@gmail.com

www.lynndentontherapy.com

PRACTICE POLICY INFORMATION AND INFORMED CONSENT

Welcome to my practice. My social work practice is for the purpose of providing therapy to children, adults and families. People seek therapy for many reasons, and I will do my best to help you explore the issues that brought you here today. However, there is no guarantee of particular results or outcomes.

Please take a few moments to review my practice policies. Please sign and return one copy to me, and keep the other copy for your records. If there is anything on this page that requires further clarification, feel free to ask.

APPOINTMENTS AND CANCELLATIONS

All appointments will be 55 minutes in length unless other arrangements have been made. You may cancel an appointment with no charge by calling 24 hours or more in advance of the scheduled appointment. Cancellations less than 24 hours in advance and no-shows will be charged $75, with the exception of emergencies. This fee is not reimbursed by insurance companies. All effort should be made to reschedule a missed appointment within the same week to help maintain continuity of care.

PAYMENT

Payment is due at the time of service. Cash and check are accepted. If you are submitting a claim to your insurance company, I will provide you with the necessary paperwork to do so, however payment is still due to me at the appointment time. Your insurance company will reimburse you directly for any portion that is covered. If you are using insurance for which I am a provider, I will file the claim and bill you for any co-pay or deductible for which you are responsible. If there is a balance unpaid by insurance, either a co-pay, deductible or non-covered service, I will bill you for that amount. Every insurance carrier is different in their coverage, so I encourage you to contact your carrier to find out at what rate mental health visits are reimbursed.

If your case requires coordination of care with other agencies, physicians, therapists, treatment programs, schools or attorneys, I will bill you for the time I am required to work on your behalf. I will let you know in advance if these requests are being made of me, or if I find it necessary to contact another provider. I generally do not bill for brief consultations of 10 minutes or less. Otherwise, I bill at the rate of $140 per hour. This would include any written documents that I need to provide and travel time if required.

CRITICAL CARE

If you need immediate care and cannot reach me, please go to the nearest emergency room or call 911.

CONFIDENTIALITY

The information that you share in a counseling relationship is confidential and cannot be shared with others. The following situations are exceptions: 1) You may authorize release of information in written form. 2) If you wish to use insurance benefits, I will provide required information to your insurance company. 3) By law, I am a Mandated Reporter in the State of Illinois and required to report suspicion of child abuse or neglect to the Department of Children and Family Services, DCFS, as well as elder abuse under the Illinois Adult Protective Services Act. 4) Under FOID guidelines (Firearm Owners Identification), I have certain legal reporting obligations.

SCHOOL STAFFINGS

Often it is beneficial to have your child's private therapist at a school staffing to facilitate continuity of care between family, professionals and school. My billing rate is $140 per hour, and I charge for travel if the school is more than 10 minutes away from my office.

I understand and agree to the above practice policies and information.

_____	_____	_____
Date	Client Signature (age 12 and over)	Client Printed Name
_____	_____	_____
Date	Parent/Legal Guardian Signature	Parent/Legal Guardian Printed Name

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CLIENT INTAKE INFORMATION

Client Name _____

Address _____

City _____ State _____ Zip Code _____ Home Phone_____

Cell Phone _____ Personal Email Address_____

Birthdate _____ Age _____ Occupation or Year in School _____

Guarantor (Person responsible for payment, if different than client)

Name _____

Address _____

Home Phone _____ Cell Phone _____Birthdate_____

Personal Email Address _____ Occupation_____

Emergency Contact

Name _____

Phone Number _____ Relationship _____

May a message be left for this person? _____

Additional Family Members/Significant Others

Name	Birthdate	Relationship to Client	Occupation/Year in School
1.			
2.			
3.			
4.			

Client Signature (age 12 and older) _____ Date_____

Parent/Guardian Signature _____ Date _____

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Notice of Privacy Practices
Receipt and Acknowledgement of Notice

Client Name: _____
Date of Birth: _____

I hereby acknowledge that I have received and been given an opportunity to read a copy of the Notice of Privacy Practices under HIPPA for Lynn S. Denton, LCSW. I understand that if I have any questions regarding the Notice or my privacy rights under HIPPA, I can contact Lynn S. Denton, LCSW at 2530 Crawford Ave, Suite 312, Evanston, IL 60201. The Notice of Privacy Practices is subject to change. You may ask me at any time for a copy of the current notice, either in person or by phone.

_____ _____ _____
Date Printed Name (for client 12 and older) Signature

_____ _____ _____
Date Parent/Guardian Printed Name Parent/Guardian Signature

Patient/Client refuses to Acknowledge Receipt:

_____ _____
Staff's Printed Name Signature

_____
Date

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Client Name _____ Date of Birth _____ Gender: M/F

Billing Address _____

Marital Status: S M W D Personal Email Address _____

OK to send correspondence? ___

If minor (under age 18), name of legal guardian _____

Home Phone _____ OK to leave message? _____

Cell Phone _____ Ok to leave message? _____

Employer Name _____

Primary Insurance

Insurance Carrier _____

Phone Number _____ Identification Number_____

Group Number _____

Subscriber Name _____ Subscriber Date of Birth _____

Secondary Insurance

Insurance Carrier _____

Phone Number _____ Identification Number _____Group Number _____

Subscriber Name _____ Subscriber Date of Birth _____

Please read the following: I give permission to **Lynn S. Denton, LCSW,** and billing staff to send required information to my insurance company or EAP. I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balance such as co-pays, deductibles, and non-covered services. I understand that there may be a fee if I fail to give 24 hour notice for cancellation of my appointment and that my insurance or EAP does not cover the cost of missed appointments.

Signed _____ Date _____

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Confidentiality with Regard to Email and Text Communications

Email and text messaging are not secure forms of communication. Emails and texts can be intercepted by third parties. I understand that if I use email or text to communicate with Lynn Denton, LCSW to discuss anything more than a scheduling issue, that I am taking the risk that the email or text might not be secure and could be intercepted. Lynn Denton, LCSW, requests that clinical information be handled through phone communication.

If I use email or text to communicate with Lynn Denton, LCSW, I am accepting these risks.

Client Signature or Parent Signature Date