The Personal Development Group, Inc.

P.O. Box 5126 Evanston, IL 60204-5126 847-686-4000, 773-635-4000

Treatment Agreement

For (print client name):_____

In order to avoid misunderstandings and to clarify procedures, the following list is offered. You are welcome to comment or make suggestions that you feel will make your therapy experience more beneficial for you.

1. The standard fee for a 55 minute session is $150.00. This fee is payable at the time of each session and may be made by cash or check. Partial payment for each session can be arranged on an individual basis. If you have an insurance plan, you are responsible only for the applicable deductible and co-payment fees as detailed for the services covered by your plan. If your insurance company denies payment for any reason, you will be responsible for payment. You may wish to check your insurance benefits for mental health treatment. If you choose to use your personal insurance to cover the cost of services, you will need to supply all necessary information to me at our initial visit.
2. If you make payments by check and the check is returned due to insufficient funds, you will be charged an additional $30.00 to the regular session fee in order to cover the bank fees.
3. Please give 24-hour notice to cancel an appointment. If you cancel a session without 24-hour notice, you will be charged 50% of our standard fee. There may be special circumstances (illness or accident) when 24 hours notice is not possible. We can discuss this on an individual basis. If you do not show up for a scheduled appointment, and you do not call, we may not be able to reserve your appointment schedule for future dates.
4. Your therapist is available to you by phone should problems arise and am happy to talk to you. There is no fee for phone calls between sessions fewer than 10 minutes. Any calls that are longer than 10 minutes will be considered partial sessions and will be billed according to your fifty minute session fee (on a prorated basis). If you leave a voice message for your therapist, I will make every effort to return your call within several hours or on the day the message was received.
5. A separate fee will be negotiated for any reports or evaluations that you may need for personal and/or legal purposes. These reports are typically not covered by insurance.
6. Any appearances in court or dispositions will be billed to you at your hourly rate.
7. Unfortunately, if you arrive late, the therapist will still need to end the session at the scheduled time. Please try to arrive on time. If the therapist is late, a fifty-minute session will still be provided.
8. The therapist will communicate with your primary healthcare provider, psychiatrist or any other individual only if you give me permission through signing a consent form to release information. Your therapy is confidential to the extent allowable by law. If you have not recently seen a primary healthcare provider, it may be possible that your therapist will recommend that you receive a physical examination to determine if there are physical issues that contribute to your psychological or mental health.
9. **This is your therapy**. We will work together at establishing your goals and will regularly evaluate your progress to ensure that you are getting what you need and want.I have received The Notice of Privacy Practices form. (please check if appropriate)

- ☐ I have received The Notice of Privacy Practices form. (please check if appropriate)
- ☐ I consent to receiving behavioral health services from The Personal Development Group, Inc. I authorize them to bill my insurance carrier(s). I instruct that payment of medical benefits be made to The Personal Development Group or their agents. (please check if appropriate)

Your signature below indicates you have read, understand, and agree without changes to the original statements above. Only changes initialed by both the therapist and the client are accepted.

Client/Guardian Date Therapist Date