Integral THERAPY
Blending Psycho-Therapy & Holistic Healing

INTEGRAL THERAPY, INC. POLICY AGREEMENT

Welcome to Integral Therapy, Inc. Starting therapy is a big decision and you may have questions. We will do our best to answer any of your questions or concerns. This form explains our policies, state and federal law and your rights about mental health treatment. You should be aware that therapy is designed to be helpful, and it may also be difficult and painful at times.

CONSENT FOR TREATMENT:

I acknowledge and agree that, I am presenting myself for treatment and medical care with Stacey Sanicki, LCPC, I authorize and consent to the administration and performance of all tests and treatments made by Stacey Sanicki, LCPC and Integral Therapy, Inc. staff and personnel. All minors must be accompanied by a parent/legal guardian for medical care except when the minor is seeking specific services for which they are not required to obtain parental consent, accompaniment or guidance, as clearly expressed by state law.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Our conversations and our notes are not shared with anyone without your written permission, with these exceptions:

1. Diagnosis and dates of service shared with your insurance company to process your claims.
2. Information you tell us about physical, sexual or elder abuse; then, by Illinois state law, we will report this to the appropriate welfare agency.
3. When you sign a release of information to have specific information shared.
4. If you tell us you are in danger of harming yourself or others.
5. Information shared with our supervisor or consultant.
6. When required by law.

Please be informed, Integral Therapy is not able to provide emergency services in times of imminent crisis. If you are in need of emergency services, please contact your medical doctor, your psychiatrist, call 911 or go to your nearest emergency room. DuPage County offers crisis intervention services and can be reached at 630-627-1700.

Please know you have the right to review and receive copies of your client file. This file can be sent to another mental health professional, treatment facility, school or medical doctor, only with your written consent.

I have read, understand and agree to the consent for treatment and confidentiality policy as well as the HIPAA, 4 page form attached.

Signature_____

Date_____

5133 Washington, Suite 6 Downers Grove, IL 60515
630-398-1023

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ELECTRONIC COMMUNICATION:

Please indicate your authorization for Integral Therapy, Inc to use the following to communicate with you. You will receive appointment conformation via email and or text.

Phone: Ok call/leave message - Yes_____ No_____ Cell phone (#)_____
Yes_____ No_____ Home phone (#)_____
Text message: Ok to text - Yes_____ No_____ Cell phone (#)_____

Email: In some cases Integral Therapy may communicate with you by email. Please indicated the following:
OK to send email regarding scheduling: Yes_____ No_____
Ok to send email regarding office/administrative information: Yes_____ No_____

Billing: Integral Therapy, Inc. prefers to send invoices by email. If you elect not to receive invoices by email, you will receive them in the mail per your billing information.
I authorize Integral Therapy, Inc. to send billing statements via email: Yes_____ No_____

Email address _____

Electronic communication in the form of text message, email or voice mail cannot be guaranteed as confidential. Knowing this, please limit your electronic communication to appointments or schedule changes. If you wish to speak about your treatment at a time other than our scheduled appointment, please leave a brief message and we will contact you by phone within 24 hours to address your concerns.

If you choose to leave us information about your treatment, please understand the limits of confidentiality and the risks associated with it.

Please do not disclose information if you are at risk of harm to yourself or someone else via text, email or voicemail, since a timely response to a life threatening emergency cannot be guaranteed. If you are at risk of harm and need immediate assistance, please contact your medical doctor, go to the nearest emergency room or call 911.

I have read and understand the electronic communication policy.

Signature_____

Date_____

Notice of Privacy Practices:

I have received and been provided to review the notice of privacy practices.

Signature_____

Date_____

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Consent for treatment of a minor:

As the custodial parent or guardian of_____

I(we) authorize and consent to services with Integral Therapy.

Signature_____

Date_____

Please provide proof of Guardianship paper if applicable

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INSURANCE, PAYMENTS AND FEES

Payment is due at the time of service. You understand you are fully responsible for all fees for services during the treatment period. If you are using insurance, it is your responsibility to understand your benefits, coverage and limits of coverage. If authorized by you to do so, Integral Therapy will submit claims to your insurance, but the final responsibility for payment is yours. Cash, check or credit card are acceptable forms of payment for services. To ensure payment, all clients are required to complete the credit card authorization section below.

Fees:

Initial assessment - $185

60-minute session (just clinical sessions OR clinical/yoga session combination) - $150

Yoga Therapy session (at this point not billable to insurance)-$100

Cranial Sacral Therapy session (at this point not billable to insurance) - $125

No show or cancellation with less than 24 hours' notice - $75

School visit (not billable to insurance) -$175.00 per hour including plus travel time

Travel Fee to home, Due at the time of service - $25.00

$25.00 **Charge for all returned checks**

I have read, understand and agree to the above policy. Including fees and charges for late cancellation or missed without notification.

Signature_____Date_____

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CREDIT CARD AUTHORIZATION

Clients are required to have a credit card on file with Integral Therapy, Inc. to receive services.

If there is an unpaid balance, the credit card on file will be charged the unpaid balance 30 days after the invoice due date.

The credit card on file will be charged $75 for a session cancellation less than 24 hours or a no show to a scheduled appointment.

By signing this form, you acknowledge you understand and agree to the above authorization information.

Signature to acknowledge: _____Date: _____

Credit card information: Circle type of card: American Express Discover MasterCard Visa

Cardholder's name (as it appears on the card):

_____

Credit card account number:

_____

Expiration date: _____Security code on back of card: _____

Billing address:

_____

Cardholder's phone #': cell:_____ home: _____

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