Art Therapy Studio Chicago, Ltd.
1579 N Milwaukee Ave Ste 210
Chicago IL 60622
www.art-therapist.org

NPI# 1770915811
EIN# 37-1737453
arttherapystudiochicago@gmail.com

Consent for treatment

Services and Fees

It is the responsibility of the client to verify insurance benefits prior to the first therapy session. Any fees that are not covered by insurance will be the responsibility of the client and the credit card on file will be charged for any overdue balances. BCBS PPO insurance policies will be billed directly by the practice. Out of network insurance clients will pay fees at the time of service and receive a receipt that can be submitted to their insurance company. If using medical insurance, the client(s) are responsible for services not covered by the insurance, including, but not limited to, copayments, coinsurance, and noncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. **If the client(s)' insurance company denies payment, the client(s) are responsible for the payment. Client(s) who change insurance companies must notify their therapist immediately.** There may be an additional fee for telephone conversations, letter writing, meetings, and other services provided that may not be covered under insurance. Clients are required to provide notice 24 hours in advance if an appointment needs to be changed or cancelled. The fee per session is $_____ dollars. The fee for a missed session is $_____ dollars. All co-pays and payments are due at the time of service.

Grievance Process

If a client wishes to file a complaint against myself or any other therapist he or she may do so by placing that complaint in writing and sending it to the Illinois Department of Professional Regulations. According to the American Counseling Association's Ethical Guidelines, attempts should be made to resolve any complaints with the therapist directly. If these attempts are not successful, the client may put the complaint in writing along with the ACA ethical codes that are believed to have been broken. If necessary, the IDPR will investigate the complaint and issue a ruling after gathering all necessary information.

Illinois Department of Professional Regulation

Complaint Intake Unit

100 W. Randolph St., Suite 9-300

Chicago, IL 60601

Artwork

I understand that at times my artwork may be shared in supervision for consultation. I understand that my art is confidential and no photographs of my artwork will be taken or any copies of my artwork will be made without my written permission. I will talk with my therapist to explore the risks or benefits prior to having any of my artwork on display at Art Therapy Studio Chicago (ATSC).

I understand that the artwork I create while receiving services at ATSC belongs to me and will be stored at ATSC until services are discontinued. I will be provided the artwork created at any time during the course of therapy and upon discharge. The therapist will make every effort to return the work back to me. In the instance that I am not able to be contacted, the therapist will keep the work for 1 year after my discontinuation of services. It is my responsibility to communicate with the therapist regarding the artwork. After one year post discharge the work will be discarded.

Client Rights, Responsibilities, and Confidentiality

Art Therapy Studio, LTD, does not discriminate against individuals based on race, color, sex, sexual orientation, gender identity, religious creed, national origin, physical or mental disability, or protected veteran status or any other characteristic protected by law.

I have received my HIPAA notification and have read and fully understand my rights as a client as well as my responsibilities.

ATSC is present in social media, such as Facebook and Instagram. Social media may be used to disseminate information, but confidentiality of client(s) is taken very seriously and your therapist will not engage in social networking with client(s). You are welcome to like or follow us, but we will not respond to any comments. I understand that communication by email and text is not encrypted. I will only communicate scheduling via text with my therapist and will not use social media to connect with my therapist. Additionally, I am aware of the limits of confidentiality as outlined in this document.

By signing below, I am indicating that my questions have been answered, and that I understand the information presented to me. I am aware of the services offered, insurance benefits, payment responsibilities and additional fees. I have been made aware of and understand the grievance process. My signature also indicates that I am consenting to receive counseling/therapy services.

_____

Signature of Client Date

Signature of Parent/Guardian Date

Signature of Therapist Date