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

License# 180-005785
NPI# 1770614315
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 and Cigna 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. 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 for a missed session is $75.00 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

Client Rights, Responsibilities, and Confidentiality

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