Janelle DiMichele, LCSW
& Associates LLC
960 Rand Road Suite 215 Des Plaines, IL 60016
(847) 699-2100

## New Client Information
(Please Print)

Last Name _____ MI _____ First Name _____

Street Address _____

City _____ State _____ Zip _____

E-mail Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate of Client _____ Sex: M F (Circle One)

Social Security Number _____

Responsible Party Telephone _____

Billing Address _____

City _____ State _____ Zip _____

Marital Status (Circle One) **M** - Married **S** - Single **Se** - Separated **D** - Divorce **W** - Widowed

Employer and Address _____ Who Referred You? _____

_____

_____

## Information pertaining to client's spouse, partner, or guardian

Last Name _____ First Name _____

Street Address _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Client _____

Birthdate _____ Spouse's Employer and Address _____

Social Security Number _____ _____

_____

## Insurance Information

Insurance Company Name _____ Phone No. _____

Insured Party Full Name _____ Relationship to Client _____

Group Name _____ Group ID No. _____

Please provide the therapist with a copy of your insurance identification card.

1. I hereby authorize the therapist whose name appears on my insurance claim form to furnish my insurance company with any requested information concerning my present treatment.
2. I hereby assign to the therapist whose name appears on my insurance claim form all monies to which I am entitled for psychological expense relative to the services reported on my insurance

_____ _____

Client Signature Date Client Signature Date

Janelle DiMichele, LCSW
& Associates LLC
960 Rand Road
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Des Plaines, IL 60016
PHONE: 847-699-2100
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# Statement of Understanding

These guidelines have been written to inform you, the client, about the basic terms, conditions and professional practices that promote a successful therapeutic experience. Please read this information carefully and acknowledge your understanding by signing below.

**Appointments**
Optimal results occur when you consistently schedule appointments and maintain regular attendance. Each session lasts 45-60 minutes. All appointments need to be scheduled in advance. **Appointments failed; cancelled or rescheduled with less than 24 hour notice will be charged the agreed upon rate. Payment will be your responsibility**. In cases of emergency or special circumstances where 24-hour notice is not possible, the late cancellation fee may be waived.

**Payment for Services**
Our fee for a 45-60 minute session is $150.00. If you choose to utilize your insurance benefits toward payment of your session, we will request pre-certification for treatment as needed, complete the necessary paperwork, and submit claims to your insurance company in a timely manner. You will be responsible for treatment not covered by your insurance. Payments are expected at the time of service.

**Confidentiality**
All information you share in therapy including case notes and records are confidential and will not be shared with anybody without your written consent or that of a legally authorized person (i.e. parent or guardian). **However, this policy does not apply in the following situations:**

1. If you use your insurance, we use a third party billing service to do our billing. They maintain our confidentiality policy.
2. If you use your EAP (Employee Assistance Program) information about your treatment will be shared with them, but NOT your employer.
3. As part of our professional development, we regularly seek clinical consultation and may discuss information about your case with another professional psychotherapist who maintains the same policy of confidentiality indicated above.
4. If we become aware that you may be a danger to yourself or somebody else, of any suspected abuse or neglect of a child/elder/dependent adult, of a situation involving stalking, or of a threat to national security, we are required by law to report this information to a designated agency.

**Contact Information**
Between appointments, please feel free to contact your therapist or leave a message at (847) 699-2100. **If you are canceling an appointment for that day, please call and leave a detailed message for your therapist.** In the case of an emergency, the client may contact our answering service at (866)312-6136 or proceed to the nearest hospital emergency room or call 911.

**Informed Consent**
I have read and understand all of the terms and conditions stated above. All my questions have been answered fully.
I understand and agree to the terms and conditions of this agreement.

| | |
|---|---|
| _____ | _____ |
| Signature of Client Date | Signature of Client Date |
| _____ | _____ |
| Printed Name | Printed Name |