Frank Gutierrez, LCPC

360 Therapy
4801 W. Peterson Ave.
#403
Chicago, IL 60646
847-650-1995

CLIENT AGREEMENT

This form requests information about you and contains important information about my professional services and policies. Please read it carefully. When you sign this document, it will represent an agreement between us.

Client Name:_____ DOB:_____

Address:_____

City, State, Zip Code:_____

Gender: ☐Male ☐Female

Relationship Status (circle): single married domestic partner separated divorced widowed

Home Phone # (___) _____ Cell phone (___) _____
OK to contact there? Y N OK to contact there? Y N

E-mail Address: _____

Occupation (if employed)/PT or FT Student?:_____

Employer's Name and address:_____

City, State, Zip_____

(____) _____
Work Phone OK to contact there? Y N

Emergency contact: _____ Relationship to client: _____

Phone (_____) _____ Cell (___) _____

Please indicate who referred you, if anybody: _____

Primary Care Physician: _____ (____) _____
Phone

Preferred Contact: ☐ Cell ☐ Home ☐ Work ☐ Email

Have you ever received mental health treatment before? If so, please list approximate dates, provider name and the issue for which treatment was sought:

_____

_____

_____

Have you ever been hospitalized for psychiatric reasons? No_____ Yes _____

Dates:_____ Facility:_____

Reason:_____

Please list any medications (and dosage) you are currently taking:

_____

_____

_____

CONFIDENTIALITY: Your verbal communication and clinical records are strictly confidential, except where: 1) the client authorizes a release of information with his/her signature; 2) the client presents a physical danger to self or others; 3) child/elder abuse/neglect is suspected. In the latter two cases, we are required by law to report this information to the proper legal authorities so that protective measures can be taken.

FINANCIAL TERMS: My private-pay fees are $130.00 ($160.00 for couples) for an appointment hour of 50 minutes duration, except for the initial evaluation period, which can last from one to three 60 minute sessions and is billed at $210.00 per session. My fees for insured clients are based upon a rate negotiated with your provider.

Other services include: report writing, telephone conversations other than for scheduling appointments, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Clients will be given 30-day verbal notice prior to any change in fee structure.

BILLING AND PAYMENT: Richard N. Goodman will bill your provider directly for services rendered. You are financially responsible for any co-payments or co-insurance due and for any non-covered services rendered (e.g., missed appointments, unmet deductibles). Co-payments are due at the time of service. I accept cash, personal checks and credit cards. There will be a $20.00 service charge on all returned checks.

CANCELLED AND MISSED APPOINTMENENTS: A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled within less than a twenty-four hours notice, you will be billed directly according to the scheduled fee,

unless we agree that it could not have been avoided. If you have an appointment on Monday, please call by Friday to cancel and reschedule your next appointment.

CONTACTING ME AND EMERGENCY PROCEDURES: If you need to contact me, please leave a message on my confidential voicemail (847.650.1995) and your call will be returned (usually within 24 hours). If an emergency situation arises, follow the emergency procedures on my phone service. Calls that exceed five minutes will be charged at my normal therapy rates.

YOUR RELEASE OF INFORMATION: I authorize the release of information regarding my care to my health plan for the payment of claims, certifications/case management decisions, and other purposes related to the administration of benefits of my health plan. Information regarding your care may be used and disclosed for the purpose of providing, coordinating or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members.

YOUR CONSENT FOR TREATMENT: I further authorize and request that my treating provider carry out mental health examinations, treatment and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may be difficult at times.

I understand and agree to all of the above information.

_____

Client (or Parent/Guardian) Signature **Date**