SHARED VISION
PSYCHOLOGICAL SERVICES
Building Healthy Connections

Consent for Psychological Services, Insurance Billing, and Financial Responsibility

Welcome to Shared Vision Psychological Services. Below, you'll find a review of our clinic's policies and procedures. We welcome your questions or concerns at any time and look forward to beginning our work together.

All-Inclusive Consent & Acknowledgments

Consent to Treatment: You voluntarily agree to receive mental health assessment, care, treatment, and services and authorize Shared Vision Psychological Services, Inc. to provide such care, treatment, and services as are considered necessary and advisable. You understand and agree to participate in the planning of your care, treatment, and services, and that you may stop such care, treatment, and services at any time.

By signing this consent form, you, the undersigned client or parent/guardian, acknowledge that you understand all the terms and information contained herein. Ample opportunity has been offered to ask questions and seek clarification. Your signature below grants consent to Shared Vision Psychological Services and the clinician coordinating your services to use and disclose your protected health information for the purposes of assessment, treatment, payment, and other healthcare operations. Your signature also provides consent for direct payment of medical benefits to Shared Vision Psychological Services, Inc. We encourage you to read this agreement in full before signing this consent.

If Applicable: By signing as a parent/guardian, you hereby give authorization and consent for the patient to receive outpatient assessment/treatment from Shared Vision Psychological Services.

- You understand it is the policy of SVPS that the parent/guardian bringing the patient is responsible for payment at the time services are rendered. You will be responsible for payment of the services rendered regardless of any financial arrangement for the payment of the patient's medical care, either oral or written, with the patient's other parent or responsible party.

- You understand that SVPS assumes no responsibility for collecting payment from the other parent or responsible party whom may have financial arrangements for the patient's medical care.

Acknowledgments: By signing below, you acknowledge the following:

- You have been offered the Illinois Notice Form outlining privacy regulations relevant to your care.

- You authorize use and disclosure of your personal health information for the purposes of diagnosing or providing treatment, obtaining payment for care, or for the purposes of conducting the behavioral health operations of Shared Vision Psychological Services. You authorize SVPS to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that SVPS may release objective clinical information related to diagnosis and treatment that may be requested by your insurance company (if applicable) or its designated agent.

- You authorize and request your insurance plan (if applicable) pay directly to SVPS the amount due for services rendered to the patient, yourself, or others covered by the insurance plan(s) under which you have registered. You authorize the release of any medical, mental health, or substance abuse information necessary to process insurance

claims for services rendered. You understand that this consent is subject to revocation at any time, except where action has already been taken on the basis of this release. This consent expires six months following the final insurance payment or final patient payment, whichever occurs later. This consent is subject to state and federal confidentiality regulation.

- You agree to take full responsibility for the entire amount due for any and all services rendered. If the provider is contracted with your insurance company, you will be responsible only for the co-pay, co-insurance, deductible, and non-covered services as determined by the insurance plan. If you do not inform SVPS in a timely manner of any changes to insurance coverage, you understand that you may need to pay for services in full if payment is denied in part or in full by your insurance carrier. You further understand that you may not be able to schedule appointments if your account becomes delinquent and/or your account is turned over to collections.

- You agree to provide a credit card to have on file in order to process payments. You grant permission for the credit card account listed to be charged per SVPS policies.

Treatment Fit and Attendance: You understand that the early sessions of psychotherapy will involve an evaluation of your treatment needs and our ability to provide the appropriate level of care and approach required. Should a referral to another resource or higher level of care be required, SVPS will provide those and work to collaborate with future treatment teams. Should you progress through a HLOC program, appropriate step-down care is necessary if and when continued care at SVPS resumes. You understand that routine attendance is pivotal for treatment gains. Recurring non-attendance at scheduled treatment sessions, even within the cancellation policy, may require us to refer you to an outside resource.

Cancellation Policies: You acknowledge that if you need to cancel or reschedule an appointment, you will provide a minimum notice of 24 hours for therapy and 48 hours for testing sessions. Otherwise, you understand that you are subject to the full cancellation fee of $120/session hour scheduled and are responsible for payment in full. *Cancellation fees are not healthcare services and cannot be billed to your insurance company.* Repeated late cancellations or missed appointments may necessitate a referral to another provider if treatment cannot unfold effectively.

Emergencies and Crisis Care: You acknowledge that SVPS is not a 24-hour crisis care facility and that you are advised and responsible for contacting 911, seeking care at the nearest emergency room, or securing assistance through another provider of choice when your SVPS therapist is not available. *If you are experiencing thoughts of harming yourself or others, call 911, go to the nearest ER, or contact the Suicide and Crisis Lifeline at 988 immediately.*

Clinical Records and Confidentiality: You understand that clinical records are maintained by SVPS in accordance with Illinois law. Patients have rights to inspect or obtain copies of their records as provided under applicable Illinois and federal law. You understand that if you choose to have your records or treatment updates provided to a third party, you must request this in writing using SVPS 'Authorization for the Release of Information 'form or another acceptable form, with the exception of information you have agreed to release per this Acknowledgment. With your authorization and consistent with applicable privacy laws and professional ethical standards, professionals within our clinic may consult and collaborate with one another regarding your care as clinically appropriate, while maintaining the confidentiality and privacy of your protected health information.

Professional Training: You further understand that SVPS upholds a commitment to professional training of doctoral residents and post-doctoral fellows. Should your assessment or treatment service be conducted by a clinician completing training and licensure under the supervision of a licensed Illinois Clinical Psychologist, this will be reviewed prior to the onset of services.

Telehealth Services Consent: Telehealth services may be utilized when clinically appropriate and agreed upon by both the patient and clinician. Telehealth coverage varies by insurance plan and applicable payer policies. Patients remain responsible for any amounts determined to be their responsibility under their health plan. Risks of phone and video sessions include: the reduction in nonverbal communication, possible service interruptions or technology

challenges, and the need to find private space for your call or video session. Should your connection get interrupted during sessions, contact your clinician to re-connect or reschedule another appointment.

Couples and Family Services: You acknowledge that couples therapy requires the attendance of both partners as scheduled by the treating clinician, and the absence of one partner will necessitate the rescheduling of the session. This may incur cancellation fees that are not reimbursed per your insurance policy. Additionally, the exploration of a couple's relationship can present the risk of separation and/or divorce. Information disclosed during family, couples, or conjoint treatment may be documented in a single clinical record; however, the identified client retains ownership of the clinical record, and any release of records will require that individual's written consent. Your therapist will review other clinical considerations framing our approach to supporting couples and families.

Telehealth Acknowledgements and Agreements: When utilizing telehealth, you request that all communications and services from Shared Vision Psychological Services (SVPS) be delivered by the provided electronic means. You understand that this form of communication may not be secure, creating a potential risk of disclosure to unauthorized individuals. SVPS utilizes HIPAA-compliant technology and reasonable administrative, physical, and technical safeguards designed to protect the privacy and security of electronic communications. Although SVPS utilizes reasonable safeguards, electronic communications cannot be guaranteed to be completely secure, and there remains a small risk of unauthorized access. When utilizing Telehealth, current location verification will occur. Upon evaluation by your therapist, telehealth may be discontinued when clinically or legally appropriate.

Electronic Communications & Messaging: By signing below, you acknowledge that SVPS may use electronic communications & messaging for the following purposes: appointment reminders, scheduling coordination, and reminders related to payment, billing, insurance, and/or account balances. *Electronic messaging should not be used for emergencies or urgent clinical needs*. We cannot guarantee, but will use reasonable means to maintain, the security and confidentiality of the information shared via electronic messaging. Further, you acknowledge the risks of electronic messaging and communications including: electronic communications can be circulated, forwarded, sent to unintended recipients, and stored electronically and/or on paper; senders can easily misaddress electronic communications and send the information to an unintended recipient; backup copies of electronic communications may exist even after deletion; electronic communications may not be secure and can possibly be intercepted, altered, forwarded or used without authorization or detection; service providers may charge for calls or messages received; employers and online providers have a right to inspect electronic communications sent through their company systems; and electronic communications can be used as evidence in court. You understand that you can opt out of electronic communications at any time by contacting your clinician.

Mandatory Reporting and Limits of Confidentiality: SVPS is committed to protecting the confidentiality of your health information in accordance with the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Health Insurance Portability and Accountability Act (HIPAA), and other applicable federal and state laws. Except as authorized by you or otherwise permitted or required by law, information obtained during the course of treatment will remain confidential. There are circumstances in which Illinois or federal law requires or permits disclosure of confidential information without your written authorization. These circumstances may include, but are not limited to:

- Reporting suspected child abuse or neglect;
- Reporting suspected abuse, neglect, or financial exploitation of an eligible adult, older adult, or adult with a disability when required by applicable law;
- Compliance with a valid court order or other lawful legal process;
- Situations involving a serious and imminent threat to the health or safety of you or another person where disclosure is permitted or required to reduce that risk;
- Medical emergencies, public health reporting requirements, or other disclosures authorized or required under applicable law;
- Professional consultation, supervision, quality assurance, accreditation activities, or billing and healthcare operations as permitted by law.

Whenever practical and legally permissible, the clinician will discuss the need for such disclosure with you before confidential information is released.

Treatment of Minors, Parents, and Legal Authority: When psychological services are provided to a minor, consent for treatment must generally be provided by a parent or other individual legally authorized to consent under Illinois law. SVPS may request copies of court orders, parenting plans, allocation judgments, guardianship documents, or other legal documents necessary to determine who has legal authority to consent to treatment and receive information regarding a child or teen's care. When there is no known dispute regarding parental authority or consent, SVPS may rely on the presenting parent's representation regarding their legal authority to consent and any relevant parenting or custody arrangements. If SVPS becomes aware of a dispute regarding consent, parental authority, or access to a minor's care, the clinic may request relevant court orders, parenting agreements, or updated legal documentation before proceeding with non-emergency care. If documentation is unclear, conflicting, or insufficient to establish legal authority, SVPS may pause non-emergency treatment or seek appropriate legal guidance. Emergency care or actions necessary to protect the minor's health or safety will be addressed as permitted or required by applicable law. Parents or guardians are responsible for informing SVPS of any changes in legal custody, guardianship, allocation of parental responsibilities, or court orders that may affect treatment, scheduling, communication, access to records, or consent.

Unless otherwise limited by law or court order, parents or legal guardians may have rights to receive information regarding their child's treatment. At the same time, effective treatment often depends upon allowing minors an appropriate degree of privacy. Accordingly, the treating psychologist may exercise professional judgment regarding the information shared with parents or guardians while keeping them appropriately informed about treatment progress, safety concerns, recommendations, and matters affecting their child's well-being.

If you and your partner are undergoing separation or divorce processes, you understand that our portal system will require you both to utilize one user identification to access your child's account. All billing is completed under one sole account, and arrangements for split-fees must occur independently of our billing process. If levels of conflict impair your ability to effectively collaborate for treatment scheduling and engagement, you agree to utilize an appropriate court-mediated process (e.g. Our Family Wizard, GAL, etc.) to coordinate successfully. Involvement of step-parents or other partners not delineated by a parenting agreement may require legal consent prior to engagement.

Court Involvement, Legal Proceedings, and Forensic Matters: The primary purpose of treatment provided by SVPS is clinical evaluation and therapeutic care. Treating psychologists serve as healthcare providers rather than forensic experts. Clinicians generally do not agree to provide expert witness testimony or forensic opinions arising from a therapeutic relationship. Unless separately retained under a written agreement, clinicians do not provide opinions regarding child custody, allocation of parental responsibilities, parenting time, parental fitness, guardianship, competency, disability determinations, or other forensic or legal issues. Requests for opinion letters, affidavits, declarations, or other legal documents are evaluated on a case-by-case basis and may be declined when they exceed the appropriate scope of a treating psychologist's role.

If you request records, reports, testimony, depositions, court appearances, consultations with attorneys, or other services related to legal proceedings, such services are considered separate professional services and may be subject to additional fees. Court appearances, testimony, preparation time, travel time, consultation with attorneys, record review, and related professional activities are generally not covered by insurance and remain the financial responsibility of the requesting party, unless otherwise required by law or court order.

SVPS reserves the right to decline participation in legal proceedings when permitted by law, when doing so would be clinically inappropriate, outside the scope of treatment, or inconsistent with our professional ethics. Nothing in this section limits the clinic's obligation to comply with a valid subpoena, court order, or other legal requirement.

Consent for Contact: You agree to have your name placed on a mailing list and an email list to receive follow-up contact from Shared Vision, including, but not limited to, newsletters, educational information, clinic updates, etc.

SVPS will not sell or provide mailing lists to any third party. You understand you can revoke this consent at any time, participation is voluntary, and declining will not affect your treatment.

Insurance Billing and Contracted Services: As a participating provider with certain insurance carriers, including but not limited to Blue Cross/Blue Shield and other third-party payers, this clinic will submit claims for covered psychological treatment and/or testing services consistent with applicable contractual obligations. Covered services are limited to those deemed medically necessary and reimbursable under the terms of the patient's insurance plan. The patient/guardian understands and agrees that:

- Verification of benefits is not a guarantee of payment;
- Preauthorization does not guarantee reimbursement;
- The clinic cannot guarantee that any services will be approved or reimbursed by an insurance carrier, even when the treating psychologist determines the service is clinically appropriate;
- Coverage determinations regarding medical necessity are made by the insurance carrier pursuant to the terms of the patient's health benefit plan and applicable law and may differ from the treating psychologist's clinical judgment;
- Insurance carriers may deny, reduce, recoup, or reclassify payment after services are rendered;
- The patient remains responsible for all applicable deductibles, copayments, coinsurance, and non-covered amounts permitted under applicable law and payer contract.

Purpose of Evaluations: Psychological and/or neuropsychological testing is conducted for clinical purposes that may include diagnostic clarification, treatment planning, assessment of cognitive, emotional, behavioral, executive functioning, learning, attentional, developmental, or psychiatric concerns, and/or recommendations for academic, workplace, or other functional accommodations. Testing services may include: clinical interviews, review of records, administration and scoring of standardized instruments, behavioral observations, interpretation of findings, report preparation, feedback sessions, and related professional activities. Assessments often generate clinical diagnoses based upon evaluative findings outlined in the testing report.

Supplemental, Administrative, Educational, and Non-Covered Services: Certain services associated with psychological treatment and/or testing are administrative, educational, consultative, accommodation-related, or otherwise outside the scope of covered medical or behavioral healthcare services reimbursed by insurance. These services are separate and distinct from covered psychological testing or routine psychotherapy procedures and may therefore be billed directly to the patient/guardian.

Examples include, but are not limited to:

- School accommodation recommendations
- Section 504 Plan documentation
- IEP-related letters or participation
- ADHD accommodation documentation for schools, colleges, testing agencies, or workplaces
- Disability verification forms
- Workplace accommodation forms
- College board/testing accommodation applications
- Supplemental narrative reports beyond the standard clinical report
- Administrative completion of forms or questionnaires
- Professional consultation with schools, attorneys, employers, disability offices, or third parties
- Extended review of outside records beyond customary preparation time
- Additional feedback sessions or follow-up consultations
- Rush or expedited services
- Court-related services, testimony, or legal consultation
- Additional copies or customized versions of reports

- Specialized testing platforms, scoring systems, administrative resources, or professional services not reimbursed by insurance

These supplemental services may not meet criteria for medical necessity under your insurance plan and may not be billable to insurance under payer rules or provider contracts. Accordingly, you agree that such services may be billed directly to you at the clinic's established fee schedule, even when other portions of the evaluation or treatment are covered by insurance.

Distinction Between Covered Clinical Services and Supplemental: You acknowledge and agree that:

- Insurance reimbursement for psychological services does not obligate the clinic to provide non-covered supplemental services without additional compensation;
- Accommodation-related documentation, educational advocacy materials, administrative forms, customized reports, and similar supplemental services constitute separate professional services beyond the scope of standard covered testing benefits;
- Charges for supplemental services are not intended to circumvent insurance contractual obligations or improperly balance bill covered services, but rather reflect separate, non-covered professional work not covered or reimbursed by the insurer;
- You may decline optional supplemental services; however, requested supplemental services may not be completed until applicable fees are satisfied.

Compliance With Insurance Contracts and Applicable Law: This clinic complies with applicable Illinois law, federal law, and contractual obligations with participating insurance carriers. Nothing in this agreement is intended to waive protections afforded under Illinois law, the federal No Surprises Act, or applicable insurance regulations. You understand and agree that:

- The clinic will not bill the patient for amounts prohibited by applicable payer contracts or state/federal law;
- Covered in-network services will be billed in accordance with the provider's contractual obligations with the applicable health plan;
- Any patient-responsibility amounts for covered services shall be limited to applicable copayments, coinsurance, deductibles, and other amounts permitted under the patient's health plan and applicable law.

Election to Receive Non-Covered Supplemental Services: You understand that certain requested services may not constitute medically necessary covered healthcare services under your insurance plan and may instead constitute optional educational, academic, occupational, administrative, or consultative services. By requesting such services, you voluntarily elect to receive these non-covered services and accept financial responsibility for associated fees disclosed by the clinic.

ADHD, Educational, and Accommodation Limitations: You understand that psychological testing performed within a healthcare setting is primarily intended for clinical and diagnostic purposes and may result in a clinical diagnosis. Educational institutions, school districts, universities, testing agencies, and employers may apply separate legal, educational, or administrative standards when determining eligibility for accommodations or services. A diagnosis does not automatically qualify an individual for accommodations, disability services, academic modifications, or legal protections. The clinic does not guarantee:

- qualification for a Section 504 Plan;
- IEP eligibility;
- standardized testing accommodations;
- academic modifications;
- disability status determinations;
- workplace accommodations;
- or other institutional approvals.

Financial Responsibility: By signing below as the patient/guardian, you agree to full financial responsibility for:

- All patient-responsibility amounts under the insurance plan;
- Services determined non-covered by insurance;
- Supplemental services described above;
- Charges resulting from failure to maintain active insurance coverage or provide accurate information;
- Collection costs, reasonable attorney's fees (where permitted under applicable Illinois law), and costs associated with unpaid balances where permitted by law.

Good Faith Estimate Notice: Consistent with applicable federal law, uninsured or self-pay patients, and insured patients who elect not to submit claims to their health plan, may be entitled to receive a Good Faith Estimate of expected charges for reasonably anticipated healthcare services upon request or as otherwise required by law

Authorization and Assignment of Benefits: You authorize the release of necessary clinical and billing information to your insurance carrier and assign insurance benefits directly to the provider/clinic, where applicable. You understand that this authorization does not relieve you of financial responsibility for amounts not paid by insurance.

Payment Schedules for Out-of-Pocket Costs: You understand that out-of-pocket costs are due on the payment schedule outlined at the onset of services found in the table below. All payments will be charged to the credit card you agree to place on file. Additional or anticipated payments may be made via your online portal account. You agree that routinely denied charges or non-payment of outstanding balances may result in the postponement of non-urgent services and may require collection activity.

Service	Financial Arrangement	Payment Type	Payment Due Date
Psychotherapy	3rd Party Insurance	Estimated costs (e.g. copayments, co-insurance)	At the time of service
Psychotherapy	Self-Pay	Full fee	At the time of service
Assessment	3rd Party Insurance	Estimated costs (e.g. copayments, co-insurance)	At the time of service
Assessment	Self-Pay/OON Insurance Plans	50% Estimated costs	Following intake appointment
Assessment	Self-Pay/OON Insurance Plans	All remaining fees	Upon delivery of testing report

- **For psychotherapy services**:
  - All estimated or agreed upon fees for therapy services are due at the time of service. Our billing specialist will provide a monthly statement of your account. If you utilize third party insurance to cover fees, all outstanding balances following claims processing are due upon receipt of your statement and will be charged to the credit card you provide.
- **For assessment/testing services**:

- Fees for non-covered supplemental services or out of pocket costs are due on the following schedule: *On the day of your intake appointment:* Following your testing intake, 50% of estimated fees are due. You understand that this payment allows the clinic to assign you a diagnostician and schedule your initial day of testing. *Upon delivery of feedback and testing report:* All remaining fees are due.

- If you are utilizing your third party insurance for testing services your plan deems medically-necessary, covered services, the following schedule applies: *On the day of service*: Your portion of estimated fees are due. Our clinic will provide the most accurate good faith estimate of your financial responsibility for the testing process as initially outlined. *Once your insurance claims are processed in full*, all remaining fees that your plan deems your responsibility are due. Should your plan cover a greater amount of testing fees than originally estimated, our billing specialist will adjust your account and promptly provide any refunds due.

Consent to Services: You voluntarily consent to our psychological services. You acknowledge that you have had the opportunity to ask questions regarding clinical services, testing procedures, billing practices, insurance coverage, supplemental fees, and financial responsibility and agree to all outlined within this document.

Patient/Guardian Signature:

Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____