Sheri Bland Solutions Ltd.
2200 Huntington Drive North; Algonquin, IL 60102
Phone: 815-355-1116 FAX: 815-356-7139
Sheribland.sbs@gmail.com SheriBlandSolutions.com

WELCOME

I am so glad that you have chosen to see counseling at this time of life, and I look forward to working with you/your family on how to gain understanding and success in the things you are seeking counseling for. Thank you for reading and completing this initial paperwork. Some of it is required for billing and laws, some if it is information that helps me to understand you better..

Please review/sign/complete:
______Policies and procedures forms (attached)
______ Payment Agreement/Credit/Debit Card Authorization form (attached)
______Complete online registration at www.schedule.care & Biography form
The Privacy Policies, HIPPA requirements and the Duty to Warn and Mandated Reporting laws are available online at SheriBlandSolutions.com or by requesting a copy in office.

Thank you!
Sheri Bland, MSW
Licensed Clinical Social Worker

Client Name:____________________________ Date:____________________

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Policies and Financial Agreements: Please read and check on the left side in blank. Your signature indicates that you have read the information in this document and agree to abide by its terms.

INSURANCE AUTHORIZATION and ASSIGNMENT OF BENEFITS:

Sheri Bland Solutions Ltd. (SBS) is an in-network provider with Blue Cross Blue Shield PPO, Blue Choice PPO, Aetna, United Health Care and Traditional Medicare. As a courtesy to my clients, I will file claims to insurance. I can provide a receipt or superbill for you to submit to insurance companies for out of network benefits or for HSA/FSA benefits. You are responsible to know your benefits and know that companies do make errors in reporting benefits; you will be responsible for your portion even if the insurance incorrectly quotes your benefit. You are responsible to get any pre-authorization for services, if required from insurance, before treatment in order for insurance to pay for services. SBS asks that you contact your insurance prior to the initiation of services to identify your benefits. SBS will work with you in obtaining reimbursement from your insurance company; however, Sheri is not responsible for resolving problems arising from any dispute with an insurance company about reimbursement or payments.

___I understand that Sheri Bland, LCSW, is a solo practitioner and does not have a staff to do scheduling, billing and insurance but does it all herself. I will assist her in my treatment by contacting my insurance if needed/requested and by making payments when requested. I agree that I will contact my insurance for any pre-authorization and I will also contact my insurance for an explanation of benefits or for problems with my claims.

AUTHORIZATION OF INSURANCE PAYMENT

I hereby authorize payment be made to Sheri Bland Solutions Ltd. for services provided to me and my dependents. I understand that I am the responsible party for all charges incurred by me or my dependent(s). I also authorize the release of any and all information required to collect or process my claims. I agree to sign over to Sheri Bland Solutions Ltd. any checks made to me for services for myself or my dependents for which I have not already paid to SBS. I understand that I am ultimately responsible for all charges, regardless of insurance benefit quotes or insurance coverage. I understand that if my account becomes overdue necessitating a collection agency, that I will be responsible for the costs of collection including reasonable attorney's fees.

Name of Client: _____________________________________ Date:_____________________________

Signature of responsible party_________________________ Date:______________________________

PAYMENT FOR SERVICES

_____**FULL PAYMENT: I understand that I will be expected to pay at time of service (either my agreed on private pay fee, my co-pay or my portion owed for co-insurance or deductible balance**.) For balances due, SBS will charge my credit card when notification of claims is complete or at month end. ALL CLIENTS MUST SUBMIT CREDIT/DEBIT card info, but can pay by casn/check. **Payment may be made by check (payable to Sheri Bland Solutions, Ltd), cash or credit/debit or HSA/FSA card.**

<u>Insurance checklist and Verification of Benefits</u> (for first time clients or if insurance has changed):

Please call your insurance company prior to your first appointment and ask the following:

1. Is Sheri in network? (yes or no) ___

Amount of co-pay/co-insurance? ___________ Do I have to satisfy a deductible/how much___________________

Fees:

SBS rate is $175 for the intake session (90791 code), $150.00 for a 55 minute session (code 90837), $130 for a 45 minute session (90834). A returned check fee is $50. A missed appointmen, no show or cancel not with 24 hour notice charge is $125 (except for emergencies, illnesses or unavoidable circumstances). Any work outside scheduled sessions (phone calls, extended emails, meetings, letters) over 5 minutes is based on $150/hour and pro-rated.

<u>Appointments</u>

_____If I am unable to keep an appointment, I will provide notification as soon as possible. If an appointment is canceled or missed without 24 hours' notice, I understand that I will be billed at a late cancellation fee of $125.00 to cover loss of income (excluding legitimate emergencies, illnesses, unavoidable circumstances or dangerous weather events) that are communicated to SBS. Appointments can be made and cancelled within 48 hours of time of service through Therapy Appointment. Multiple missed/late cancel appointments may result in making a deposit of $125 for future appointments or being terminated from treatment.

<u>TELEHEALTH appointments are available</u>**

___There are several options for "telehealth" phone or video sessions, so there is not a need to cancel or have a face to face appointment, should a situation or illness occur that you can not come into the office. Please contact Sheri regarding telehealth. This can also avoid a $125 late charge or no show fee.

___Should I elect telehealth services, I consent to treatment through the platform chosen. Sheri has HIPPA compliant online platforms available for use. If I chose to use an alternate, I understand those are not HIPPA complaint.

<u>Emergencies</u>

_____Mental health emergencies are not managed in this out-patient office. You are to call 911, go to your nearest hospital emergency room for services, contact your medical doctor or call the McHenry County Crisis Line at 800-892-8900. I cannot address emergencies via texting or email.

<u>Communications</u>

____I understand that email and texting are a means to communicate information regarding appointments. These are not a means to conduct therapy nor a way to communicate serious mental health issues. I understand that texting and emails are not private and confidential, so if I choose to communicate in that way, the communication is no longer confidential and protected. If I desire to have private communications, I can message Sheri through the HIPAA compliant, encrypted message system through my Therapy Appointment profile. By signing this, I consent to communicating non-therapeutic information via email or texting, should I choose to do so.

____COVID-19 Consent: If I choose in person sesions, I agree to hold harmless Sheri Bland and Sheri Bland Solutions should I be exposed or contract COVID-19. I will not come to session if I have it or have symptoms, and sessions may go back to telehealth at any time for precautions and safety. I will wear mask in waiting room, sanitize and do social distance.

Privacy and Confidentiality; Consent for Outpatient Treatment

My signature affirms that I have reviewed and understand the "Notice of Privacy Practices (NPP) ". (Copy available in office, on website or upon request). By signing below, I am consenting to treatment provided by Sheri Bland Solutions, Ltd. for myself (adult) or my dependent (minor). I may terminate services at any time, by communicating that to Sheri Bland, and I agree to pay for all services rendered. Sheri Bland reserves the right to terminate services if I am not following treatment recommendations or do not pay the amount owed for services.

_______I understand that Sheri Bland, LCSW, does not testify in court cases.

____ I understand that information regarding me and my personal protected health information is confidential and will not be shared unless I have signed a written consent to release information or revoked that consent. Exceptions include: court order, clear and present danger to self or to others, or suspicion of child, elder or person with disability neglect/abuse. (Request hand out/view on website for Mandated Reporting and Duty to Warn statutes. Sheri Bland is a mandated reporter.)**

I have read, initialed the statements and understand the above statements:

Signature of client____Date:____________________
(if over age 12)
Signature of Guardian (if over age 12-17:) ________________________________Date:____________________

_____ **MINOR PATIENTS in DIVORCE SITUATIONS:** (initial NA if not applicable) Sheri Bland Solutions looks to the adult who has brought the child in for therapy to be responsible for the payment of services rendered to that child. We also expect the parents/guardians to work out payment and agreements for therapy with each other and not involve Sheri Bland in any disputes which may arise. The parent/guardian accompanying a minor to therapy is responsible for full payment (regardless of insurance coverage) and will be set up as the person who receives the bill for services.
_____**MINOR PATIENTS attending sessions without parent:** After the initial intake, minor clients will be seen for session without parent present only with prior agreement of parent and therapist, and only if payments are made as required.

Referral source:

I found out about Sheri Bland through: (fill in blank with: friend, family, doctor, google, psychology today, other) ___________________________________

Client consent/Waiver for Primary care physician notification:

Illinois law (PL 86-1434) requires that therapists notify a client's Primary Care Physician (PCP) that client is receiving mental health treatment, unless the client waives such notification. Please indicate your choice and write N/A if it is not your choice)

I ____DO authorize my therapist to notify my primary care physician.
Name: ____Town: Phone:______________________
_______ I do not have a PCP

_______ I waive notification

Client signature: (age 12 +) _______________________________________ Date:_______________________________

Parent/guardian signature: (ages 12-17)______________________________Date:_______________________________

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Payment for services Agreement/Credit or Debit Card Authorization

Payment at time of service: Co-pays, co-insurance and payments towards deducitble and self-pay fees are due at time of service. **Outstanding Bills**: It is not our policy to carry balances with our clients. Balances are due within 2 weeks of billing. **Missed Sessions:** Any missed sessions or cancellations without a 24-hour notice will be charged to your designated credit card at the rate of $125 per occurrence, for loss of income. ____

****ALL CLIENTS need to have a credit/debit/HSA or FSA card number on file. If you desire to pay in cash or check, you can let Sheri know and pay at time of service.

Client Name:________________________________

Cardholder Name:____

Card type:____

Credit Card Number:_____________________________________

Expiration Date:____________ Security Code:(CVV)____________

1. ___I agree to the terms above and will authorize you to bill my credit/debit card for copays, payments towards deductible, unpaid balances due and missed/late cancel appointments.

_____________________________________ ________________
Signature Date

Date