ALLIANCE COUNSELING & COACHING of ILLINOIS, LLC

CHILD HIPAA FORM

We are required by federal law, known as the **Health Insurance Portability and Accountability Act (HIPAA)**, to provide you with this form for your review and signature.

The federal government has responded to the rapid growth of computer technology and its use in healthcare by strengthening legal protections for the privacy of personal health information. Please note that Alliance Counseling & Coaching of Illinois, LLC, has always, and will continue to, maintain the highest standards for protecting our clients' personal information. You can be assured that our practice goes beyond what is required by HIPAA in its efforts to protect healthcare information.

HIPAA was created to standardize and safeguard the privacy of health information, particularly as it is shared electronically. As a result, all healthcare providers are required to review and comply with HIPAA regulations regarding how health information is created, stored, used, and shared through computers, the internet, phones, faxes, copiers, and paper records.

Treatment: Therapy continues until the client and/or therapist determines that treatment should be terminated. In most cases, this decision is reached mutually by both the client and the therapist.

Therapy is most effective when the client is open to exploring new ways of coping, actively participates in the therapeutic process, communicates honestly and openly, asks questions, and shares any concerns with the therapist—especially if the client feels frustrated or believes therapy has reached an impasse.
The terms "short-term" or "long-term" therapy can be misleading. Effective and comprehensive treatment involves allowing sufficient time for healing and for making meaningful, lasting changes in one's life. The one or two hours per week spent in therapy is minimal compared to the many hours, weeks, or even years of distress a client may have experienced prior to beginning therapy.

Consultation: As part of providing effective treatment, your therapist may occasionally consult with another therapist, psychologist, primary care physician, or other healthcare provider regarding your care. If your therapist determines that such consultation is necessary and beneficial to your treatment, you will be informed. Any professional with whom your therapist consults is bound by professional ethics and applicable laws to maintain the confidentiality of your information.

Confidentiality: We will use and disclose your protected health information only for purposes related to **treatment, payment, and healthcare operations**, as permitted by law. Your health information will not be used or shared for any other purpose unless we have obtained your voluntary written authorization. We will use your health information to provide you with the best therapeutic care possible. This may include, but is not limited to, administrative and clinical procedures designed to optimize scheduling and billing. Your health information may be included on invoices or insurance claim forms submitted by mail or electronic means to obtain payment for services rendered.

Please note that once your information is released to your designated insurance company or to an address or entity you have authorized, we no longer have control over how that information is handled.

All information disclosed within sessions and records pertaining to those sessions are confidential and may not be revealed to anyone without the therapist's written permission, except where disclosure is required by law. Licensed Therapists are mandated by law to break confidentiality if a client reveals in a session, she/he is a danger to self or others, where there is a suspicion of child, dependent, or elder abuse, neglect, or court ordered disclosures (i.e., divorce, child custody, disability).

Emergencies: We do not provide 24 hour emergency services. If an emergency should arise, please call 911 or go to the nearest emergency room.

Insurance: Disclosure of confidential information may be required by your health insurance carrier or EAP in order to process claims. You must be aware that submitting an invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers or the National Medical Data Bank. Clients are encouraged to check with their insurance company to find out how their information is kept confidential. You may contact the Medical Information Bureau (MIB) for a copy of your health data information that is provided and/or used by insurance companies.

Financial Responsibility: I understand that I am financially responsible for this treatment and that payment is expected by mutual agreement at the time of service. I understand that Alliance will assist me in submitting claims to my insurance company, but that I am ultimately responsible for any portion of the fees not reimbursed or covered by my insurance provider. Overdue accounts may be sent into collection if payments are not received in a timely fashion.

If you fail to pay on time and [Creditor] refers your account(s) to a third party for collection, a collection fee of 33.3% will be assessed and will be due and owing at the time of the referral to the third party.

Insurance companies do not cover sessions that were scheduled, but not kept. When you make an appointment, you are reserving time on the therapist's schedule that is no longer available to another client. If you need to cancel, a 24 hour notice is required. Failure to do so will result in a Late Cancel/No Show Fee. To cancel or reschedule an appointment, please call 815-467-8181 or your therapist's cell phone number, if one was provided to you. The time a voicemail is left will be noted.

Fee schedule: Initial Evaluation $250; 60 Minute Session $200; 45 Minute Session $175; Late Cancel/No Show Fee $125

Acknowledgement and Agreement: By signing this form, I am consenting to Alliance Counseling & Coaching of Illinois, LLC's use of my health information to carry out treatment and to obtain payment for services. I understand that my health information may be released to my insurance company to obtain payment for services received.

In consideration of therapeutic services to be received, I do hereby assign and transfer to Alliance Counseling & Coaching of Illinois, LLC., my rights and interest in my health insurance policies for claims that are filed on my behalf to the extent benefits are available.
I have read the above information and acknowledge, understand, and agree to all of the above information.

Printed Name(s): _____

Client Signature: _____Date:_____

Parent Signature:_____ Date: _____

Parent Signature:_____ Date: _____

ALLIANCE COUNSELING & COACHING of ILLINOIS, LLC
CHANNAHON-JOLIET–PLAINFIELD-NEW LENOX
815-467-8181

Date Modified: January 2026