8 S. Michigan Ave., Suite 2100
Chicago, IL 60603

SANKOFA
PSYCHOLOGICAL SERVICES

P. 312-344-1081
F. 312-488-4624

Contact Information

Please fill out the following information. Your information will remain confidential.

Patient Last Name _____ Patient First Name _____

Preferred Name _____ Date of Birth _____/_____/_____

Marital Status: Single Married Other Employment Status: Employed Unemployed

Cell Phone (_____) _____ _____ Alternate (_____) _____ _____

Okay to leave voicemail? **Y / N** Okay to leave voicemail? **Y / N**

Email address _____

Home address_____

Alternate address_____

Primary insured name_____ Date of Birth_____/_____/_____

Emergency Contact:

Contact name _____ Relationship_____

Cell Phone number (_____) _____ _____ Alternate (_____) _____ _____

Second Emergency Contact:

Contact name _____ Relationship _____

Cell Phone number (_____) _____ _____ Alternate (_____) _____ _____

For patients who are under the age of 18:

Parent One/Legal Guardian: **(if different from above)**

Name_____ Relationship_____

Address_____

Cell phone number: (_____) _____ -_____ Alternate: (_____) _____ -_____

Parent Two/Legal Guardian: **(if different from above)**

Name_____ Relationship_____

Address_____

Cell phone number: (_____) _____ -_____ Alternate: (_____) _____ -_____

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INFORMED CONSENT, PRACTICE POLICY, AND PROCEDURE

ABOUT OUR SERVICES: Sankofa Psychological Services, LLC, provides primary psychological and psychiatric care to individuals, couples, families, and groups. Clinicians within our practice provide professional services relating to the diagnosis, assessment, evaluation, treatment, and prevention of psychological, emotional, and psychiatric disorders and distress in individuals across the lifespan.

CONFIDENTIALITY: The staff of Sankofa Psychological Services, LLC, abides by the stipulations regarding confidentiality as contained in the Illinois Confidentiality Act and the Mental Health Code, as well as the applicable licensure laws governing the license(s) of mental health professionals and those of such professional organizations as the American Psychological Association and American Medical Association. Our practice is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A client's information will remain confidential by law except in the following circumstances: diagnosis and dates of service shared with insurance companies for the purpose of collecting payment, legally mandated reporting of abuse of children, elderly, or disabled person, suicidal/homicidal threats, information released as outlined in HIPAA, and information necessary for supervision or consultation within Sankofa Psychological Services.

MEETINGS: Your provider will typically conduct an intake assessment during your first visit. Frequency, length, and reason for subsequent visits vary and will be determine by your therapist or psychiatrist. Recurring psychotherapy appointments typically last between 45 and 50 minutes, and recurring psychiatric appointments vary in length between 20 and 50 minutes depending on type of appointment. Please arrive on time for your appointment. If you arrive late, your appointment will end at the originally scheduled time.

PROFESSIONAL FEES: Fees for Sankofa providers vary according to training, type of service, and clients' resources. Ask your individual clinician about the details of their hourly fee and which insurance plans they are able to take. Services for legal proceedings may be billed at a higher rate, depending on the service. Fees for assessment services vary greatly by the nature and duration of the assessment, and you are encouraged to discuss these fees before testing commences. Cancelled appointments without 24 hours' notice, or failure to arrive for your scheduled appointment will result in a cancellation fee.

BILLING AND PAYMENTS: Payment is due at the time of service, unless otherwise negotiated with your provider. We request a credit card to hold on file for general billing purposes, and we reserve the right to charge your credit card without notice if payment is not received within 30 days of initial invoice or within 90 days of the date of service. No show and cancellation fees will automatically be charged to the card on file.

INSURANCE REIMBURSEMENT: If you plan to use insurance, please read and understand your policy benefits for mental health coverage prior to your first session. Although Sankofa staff members may contact your insurance company on your behalf, it is your responsibility to understand your policy. If your clinician is not a participating provider with your insurance company, you have the option to utilize your out of network benefits. If you choose to do so, we require payment in full on the date of service.

CONTACTING SANKOFA STAFF: Sankofa staff members make every effort to return voicemail within one (24 hours) business day. If you need to reach a mental health care professional immediately, dial 911 or go to your nearest emergency care provider.

PROFESSIONAL RECORDS: The laws and standards of mental health professions require that Sankofa Psychological Services, LLC, keeps treatment records. You are entitled to receive a copy of your records, or your therapist can prepare a summary for you. Clients may be charged an appropriate fee for any professional time spent in responding to information requests.

MINORS: Parents of children under 12 years old will receive regular updates and general information about treatment, but therapists keep many of the details of individual sessions with children private to promote therapeutic growth. Parents of children between 12 and 18 years old will receive information about the therapeutic process through family discussions. If a Sankofa staff member feels there is a high risk that an adolescent client will harm himself/herself or someone else, the therapist will notify authorities and/or guardians for safety reasons.

VOLUNTARY CONSENT

Please read the following statement and sign below: I acknowledge that I have, read, understand, and agree to the terms as outlined in the "Informed Consent, Practice Policy, and Procedure" document. I do hereby consent to take part in mental health services. I understand that no promises have been made to me as to the results of these services or of any procedures provided by this mental health professional, and that I may withdraw my consent at any time. My signature below means that I have freely agreed to participate as a client at this time.

_____	_____	_____
Client's Signature	Client's Printed Name	Date
_____	_____	_____
Sankofa Staff Signature	Sankofa Staff Printed Name	Date
_____	_____	_____
Parent/Guardian (if applicable)	Parent/Guardian (if applicable)	Date

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Acknowledgment of HIPAA

I acknowledge that I been offered a copy of Sankofa's privacy practices and can access them at www.sankofapsychology.com (HIPAA-Health Insurance Portability and Accountability Act).

E-mail Use Authorization

(Circle one) **AGREE or DO NOT AGREE** to allow Sankofa Psychological Services, LLC to send e-mails to the e-mail address I have provided. If I agree, I understand that I can opt out at any time by replying STOP to any e-mail I receive.

Financial Responsibility Policy

I understand I am financially responsible for any and all charges incurred from Sankofa Psychological Services, LLC, including charges unpaid by my insurance carrier. I hereby assign payments to be made to SANKOFA PSYCHOLOGICAL SERVICES, LLC or any of its representatives on my behalf for services provided to me by any member of the group practice. **Please select:**

___ My clinician is a participating provider with my insurance carrier. I authorize Sankofa Psychological Services to bill my insurance carrier and to directly receive reimbursement for services provided. **I am responsible for any remaining balances.**

____ My clinician is **NOT** a participating provider with my insurance carrier, but I wish to use my out of network benefits. I understand that I am required to **submit payment in full at the time of service**, and that Sankofa Psychological Services will assist me with submitting claims for personal reimbursement from my insurance carrier, should I elect to do so.

___ I do not have insurance or elect not to use it and will self-pay $_____ per session.

Payment Due at the Time of Service

All co-pays, co-insurances, or other balances are due at the time of service. Failure to do so will result in your appointment being rescheduled.

Credit Card on File Policy

Sankofa Psychological Services, LLC ***requires*** a valid credit card on file for general billing purposes. This information is stored in a secure system and cannot be accessed by office staff once entered.

□ I authorize Sankofa Psychological Services, LLC to charge my credit card for any account balance.

OR

□ I wish to be notified of any account balance and wish to select my preferred method of payment. I understand that my credit card will be charged if payment is not received within **30 days of invoice**. I further agree to allow Sankofa Psychological Services to **charge the fee to the credit card** on file for general billing purposes. **Payments that are more than 30 days overdue will be charged a $20.00 late fee every two weeks thereafter until payment is made.**

Delinquent Accounts

We reserve and will exercise the right to report any account 90 days past due to a Collection Agency. All expenses incurred as a result will be the patient's responsibility, as permitted by law.

24 Hour Cancellation Policy

Sankofa Psychological Services, LLC has a 24 hour cancellation / rescheduling policy. **If you miss your appointment, cancel or change your appointment without at least 24 hours' notice, you will be charged a fee. ALL cancellation fees will be charged to the card on file without prior notice.** My provider charges $_____ per missed or cancelled session. **Provider Initials ____**

By signing below, you acknowledge that you have read and understand the policies outlined on this document.

_____	_____	_____
Client's Signature	*Client's Printed Name*	*Date*
_____	_____	_____
Sankofa Staff Signature	*Sankofa Staff Printed Name*	*Date*
_____	_____	_____
Parent/Guardian (if applicable)	*Parent/Guardian (if applicable)*	*Date*

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Credit Card Information
Please Print Clearly

Name as it appears on the card: _____

Name of client: _____

Complete billing address: _____

□ Visa □ MasterCard □ Discover **Card #: _____-_____-_____-_____**

(We do not accept American Express)

Expiration date: _____