

**Liz Suran, M.Ed., LCPC**  
**1300 W. Belmont, Chicago, IL 60657**  
**312.399.0559**

**SERVICE AGREEMENT AND CONSENT FOR TREATMENT**

Please Print

CLIENT'S NAME \_\_\_\_\_  
PARENTS' NAMES (If client is a minor) \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
EMAIL ADDRESS \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

**CONSENT FOR TREATMENT OF CHILDREN AND ADOLESCENTS:** I/We consent that \_\_\_\_\_ may be treated as a client or clients by Liz Suran, M.Ed., LCPC.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

**CONFIDENTIALITY AND EMERGENCY SITUATIONS:** Your verbal communication and clinical records are strictly confidential except for: a) information you and/or your child(ren) report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this information to the Illinois Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) when you sign a release to have specific information shared, d) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact emergency services directly. Liz Suran, M.Ed., LCPC will follow-up those emergency services with standard counseling and support to the client or the client's family.

Signature(s) \_\_\_\_\_ Date \_\_\_\_\_

**FEES AND INSURANCE:** Clients are expected to pay at the time of service. Fee for a 50-min session is \$90.00. Fees will vary if client chooses to use their insurance plan(s) and will be based on contracted rates between the insurance company and this therapist. If using medical insurance, the client is responsible for services not covered by the insurance, including, but not limited to, co-payments, co-insurance, and uncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. If the client's insurance company denies payment, the client is responsible for payment. *Clients who change insurance companies must notify their therapist immediately.* A change of insurance while in therapy may mean that the client may no longer be covered and therefore responsible for payment. I sincerely appreciate your cooperation. If at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

**APPOINTMENT CANCELLATION POLICY:** Clients are expected to give their therapist a minimum of 24 hours notice to cancel (or to change) an appointment. Failure to give 24 hours notice will result in a full fee for the cancelled session. Extenuating circumstances are considered when appropriate.

**CONTACTING THERAPIST:** Clients may leave confidential voicemail messages for their therapist at any time. During business hours (9:00am to 6:00pm) therapist checks voicemail regularly and will make every effort to return telephone calls within 24 hours, unless out of town. In the event of an emergency, clients are strongly encouraged to call 911 or go to the nearest emergency room.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_  
Client Signature \_\_\_\_\_ Date \_\_\_\_\_  
Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_