Dr. Swati Varma, LLC

SERVICES CONTRACT

What to expect from my initial visit?

During our initial session, we will go over your current concerns and identify treatment goals. It may take 1 to 3 sessions to gather an initial assessment, and I may ask your permission to contact previous providers or other professionals (ie: school teachers, school social workers etc.) to obtain past and/or current treatment information. This allows me to obtain the necessary information to fully understand your concerns and my ability to assist you. This is also an essential time to make sure I am able to meet your personal and clinical needs. If you choose not to receive services from me, I am able to provide you with other referrals that may better assist you.

What can I expect from therapy?

Therapy consists of regular meetings over an extended period of time. The amount of time we meet may vary from person to person. It involves creating a safe space, building skills, knowledge, and insight to help address your treatment goals.

What are your credentials and clinical background?

I have a doctoral degree in clinical psychology from the Chicago School of Professional Psychology, which is accredited by the American Psychological Association (APA). I am licensed through the state of Illinois, and a member of the Illinois Psychological Association (IPA). I specialize perinatal mental health which includes working with parents during and post-pregnancy. I also specialize in working with children, adolescents, young adults, and families to assist with anxiety, depression, trauma, ADHD, behavioral concerns, and school refusal.

How much do services cost?

My out-of-pocket fee is $175 per therapy session. Your sessions may also be covered through your health insurance plan. If your health insurance will pay for part of my fee, I

will complete the insurance claim forms. It is notable that you may have a co-pay, as a result of your particular insurance plan and related benefits. Payments for sessions and/or co-pays are expected at the beginning of each session in the form of cash, check, or credit card.

What if I need to cancel or reschedule a session?

All cancellations of appointment must be made 24-hours in advance of the scheduled session. If you do not call to cancel and/or fail to show, you will be charged a $135 cancellation fee. If you need to reschedule, please contact me as soon as possible and we can figure out another time to re-schedule.

What if I need to contact you before my scheduled appointment?

If you are in an emergency situation, please call 911 or proceed to your nearest emergency room. You may call my telephone and leave a message on my confidential voicemail.

Are my visits confidential?

The information you share in therapy is confidential and cannot be shared without your written permission. There are some exceptions to confidentiality including: (1) If you are at imminent risk to harm yourself or another person, the law requires me to try to protect you and/or the other person by informing appropriate individuals to maintain safety; (2) If you disclose information pertaining to child or elder abuse, the law requires me to report this to authorities; and (3) If I receive a court-order for your clinical record or to testify. If such rare situation(s) occurs, I will make every effort to fully discuss it with you before taking action.

I certify by my signature below that I have read, fully understand, and agree to abide by the terms of the Services Contract.

_____ _____
Signature of Client Date

_____ _____
Swati Varma, Psy.D. Date

IN ADDITION FOR CHILDREN AND ADOLESCENTS:

I certify that I am the parent/legal guardian and have legal custody of _____. I authorize and consent for my child to receive

outpatient therapeutic services from Swati Varma, Psy.D. I understand that I am responsible for the payment of my child's treatment.

In addition, it is important for you, as the parent/legal guardian to understand the following information that may relate to your child's treatment, including:

- If you decide to terminate treatment, I have the option of having a few closing sessions with your child to properly end the treatment relationship.
- I will inform you if your child does not attend the treatment sessions.
- If necessary to protect the life of your child or another person, I have the option of disclosing information to you without your child's consent.
- You agree that my role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
- You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.
- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, I will provide general information about the child which will not include recommendations concerning custody or custody arrangements.

If, for any reason, I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $175 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

_____ _____
Signature of Client Date

_____ _____
Swati Varma, Psy.D. Date

Swati Varma, Psy.D. || Licensed Clinical Psychologist
T: 312.380.9532 || Drswati.psyd@gmail.com

Dr. Swati Varma, LLC

FINANCIAL CONTRACT

This contract outlines my financial policy. My fee is $175 per therapy session. My services are also covered by Blue Cross/Blue Shield PPO, Blue Choice PPO, United Health Care PPO/Optum, and Aetna. After receiving your benefits summary, we can clarify your co-payment and deductible for which are your financial responsibility. Payments for sessions, co-pays, and/or deductibles are expected at the beginning of each session in the form of cash, check, or credit card.

If you have other insurance than what is listed, your plan may cover out-of-network services. However, it is your responsibility to contact the insurance company to investigate information related to mental health benefits. If needed, I will provide monthly statements to submit for reimbursement as an out-of-network provider, and you will be responsible for any associated fees for services.

If paying your bill in a timely fashion becomes an issue at any point, please discuss this with me so we can come to a solution. If no solution has been discussed and your account has not been paid for more than 60 days, a collection agency may be used to secure payment.

Payment Method: ☐Cash ☐Check ☐Credit Card ☐Insurance

Insurance Information (Please complete or provide copy of your insurance card):
Insurance Company:
_____
Subscriber Name: _____
Subscriber DOB: _____
Identification/Policy #: _____
Group or Enrollment #:_____
Insurance Company Phone #: _____

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Please initial the following:

_____ *Financial Relationship*
I agree that a financial relationship with this therapist will continue as the therapist provides services to me. I agree to pay for services provided through termination of services.

_____ *Accepting Financial Responsibility*
I understand that I am ultimately responsible for the services provided by this therapist to me, although other persons or insurance companies may make payments to my account.

_____ *Authorization for release of information for billing purposes*
I hereby authorize the release of any information necessary for third-party submission and/or payments for services. I authorize third-party benefits to Dr. Swati Varma/Dr. Swati Varma, LLC for mental health services described herein.

_____ *Cancellation Policy*
Any cancellations of appointments must be made at least 24 hours in advance of the scheduled session. If I do not call to cancel and/or fail to show, **I will be charged a $135 cancellation fee for the appointment.**

_____ _____
Signature of Client Date
(or person assuming financial responsibility)

_____ _____
Swati Varma, Psy.D. Date

Swati Varma, Psy.D. || Licensed Clinical Psychologist
T: 312.380.9532 || Drswati.psyd@gmail.com

Dr. Swati Varma, LLC

CREDIT CARD AUTHORIZATION

I wish to authorize ongoing payments for sessions or late cancellations from Swati Varma, Psy.D., using this credit card authorization form. Credit card transactions will be done through the Ivy Pay application, which is a HIPAA compliant credit card processing company. I further authorize from Swati Varma, Psy.D., to maintain my card information on file. I agree that I will pay for these sessions or late cancellations and indemnify and hold Swati Varma, Psy.D, harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as authorized signature on the credit card charge slip. This authorization will remain in effect until such time when a written request to cease charges is received. Swati Varma, Psy.D, will process all charges using a secure credit card service. Charges will be processed to the above stated account 1 to 5 business days after the session date or late cancellation.

_____	_____	_____
Printed Name	Signature	Date

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