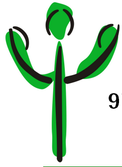


Hawthorn Counseling Group
977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061 (847) 680-0755 • www.hawthorncounseling.com

Parent Coordination Client Registration Packet

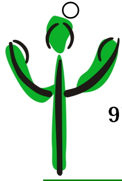
Welcome to Hawthorn Counseling Group. Completing the registration packet is the first step towards getting the help you are seeking and we look forward to working with you to achieve your goals for counseling. Please note the following about the attached forms:

- ✓ Each parent is to complete a separate packet of forms and return to Dr. Jochem
- ✓ Please complete the client registration form.
- ✓ Please complete the Co-Parenting Consultation Agreement.
- ✓ All clients are asked to complete the attached *Payment Agreement*. Please provide credit card billing information. As explained on the form, you may use cash or check to pay for services provided however your credit card may be utilized for collection of unpaid balances resulting from deductibles, copays, late cancellation or failed appointment charges.

Please pay special attention to our policies regarding late cancellations or failed appointments:

- o If you need to reschedule an appointment, Hawthorn Counseling Group requires at least <u>24 hours' notice</u>—a full business day in advance of the hour of your appointment—giving notice of the intent to cancel a scheduled appointment. Also, please note: appointments scheduled on Mondays (or Tuesdays if following a holiday weekend) must be canceled by 5:00pm the preceding Friday afternoon. If you have a scheduling conflict and must cancel an appointment it is sufficient to leave a voicemail message in your specific clinician's voicemail box by calling 847-680-0755, then entering the mailbox extension for your HCG clinician. This notification must be provided a full 24 hours (or one business day) in advance of the hour of the scheduled appointment in order to avoid being billed for the appointment. We are unable to make allowances or exceptions to this policy, except in cases of sudden serious illness, family emergency or severe inclement weather. Be advised that business/work conflicts, scheduling of kids' athletic or school events, unexpected travel or other similar circumstances which might arise are not deemed as grounds for waiver of the late cancellation policy.

- o With regard to late cancellations or failed appointments, you will be charged the full usual and customary fee for one hour of scheduled service.



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CLIENT REGISTRATION INFORMATION

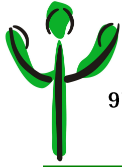
PLEASE PRINT

Client Information					
Last Name	First Name	MI	Date of Birth / /	Age	Sex

Address	Apt. #	City	State	Zip

Home Phone	Work Phone	Cell Phone

Hawthorn Counseling Group is a registered dba in the State of Illinois for John D. Jochem, Psy.D., P.C.



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PAYMENT AGREEMENT **Patient Name:** ____

In consideration of the services to be rendered by the clinicians of Hawthorn Counseling Group (HCG), I agree to pay HCG for all services provided to the patient, at the established rates listed in the HCG fee schedule in effect at the time services are received, or as otherwise negotiated with HCG.

I also understand that I am financially responsible for any failed appointment & late cancellation charges.

I certify that the information provided to HCG is, to the best of my knowledge, complete and accurate. I will make arrangements for prompt and regular payment of fees to HCG for services. I understand that payment is due either in-full or in-part at the time services are provided, as arranged when services are initiated.

I understand that I may pay by cash or check. I grant permission to HCG to bill my credit card account or flex spending account noted below for payment of any charges. This includes payment of any unpaid balances which are 30 days or more past due, including co-payments, deductibles, failed appointment & late cancellation charges.

In understand that credit card charges will show on billing statements as “Hawthorn Counseling Group”.

All patients are asked to provide credit card billing information below:

TYPE OF CREDIT CARD: ☐ VISA ☐ M/C ☐ FLEX SPENDING ACCOUNT ☐ DEBIT CARD

NAME OF CARD HOLDER:

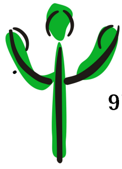
PRINT

ACCOUNT NUMBER:

EXPIRATION DATE:

AGREEMENT AND AUTHORIZING SIGNATURE:

*X*____________________________________



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977 Lakeview Parkway, Suite 102, Vernon Hills, IL 60061 (847) 680-0755 ● fax: (847) 573-1617

www.hawthorncounseling.com

Parent Coordination Services Agreement

This form is the written expression of my voluntary consent to engage Hawthorn Counseling Group (HCG) to provide Parent Coordination (PC) services. I understand that the process is a joint effort and that results cannot be guaranteed. I understand that I may withdraw from consultation at any time.

I understand that services provided through PC are distinct from other mental health services. PC services provided by HCG do not include psychological assessment, diagnosis or treatment of a mental health condition. Instead, PC services often include the services listed below (adapted from Circuit Court of Cook County, Illinois), which may be expanded, excluded or modified by the court in my particular circumstance:

1. The parenting coordinator shall educate, mediate, monitor court orders and make recommendations to the court as necessary. In addition, the parenting coordinator may recommend approaches that will reduce conflict between parents and reduce unnecessary stress for the children.

2. The parenting coordinator may monitor parental behaviors and mediate disputes concerning parenting issues and report any allegations of noncompliance to the court, if necessary.

3. The parenting coordinator may recommend outside resources as needed, such as random drug screens, parenting classes and psychotherapy.

4. The parenting coordinator may recommend detailed guidelines or rules for communication between parents.

5. The parenting coordinator may maintain communication among all parties by serving, if necessary, as a conduit for information.

6. The parenting coordinator may meet with the parties, the children, and significant others jointly or separately. The parenting coordinator shall determine if the appointments shall be joint or separate.

7. Each parent is encouraged to direct any disagreements or concerns regarding the children to the parenting coordinator.

8. The parenting coordinator works with both parents to attempt to resolve conflicts and, if necessary, may recommend an appropriate resolution to the parents.

9. The parenting coordinator does not have any decision-making authority which is the sole province of the court.

10. The parenting coordinator does not serve as a court's professional (as provided in 750 ILCS 5/604.10(b)) in any proceeding involving one or more parties for whom the parenting coordinator has provided parenting coordination services.

11. The parenting coordinator will not give a recommendation or opinion concerning any ultimate issue of fact, law, or mixed issue of fact and law, as to allocation of parental responsibilities, visitation by a non-parent, or relocation. The PC will not provide legal opinion or guidance.

I understand that services provided through coparenting consultation are confidential and release of information to parties outside of the coparenting consultation process will require my consent. There are, however, circumstances under which information may be released without prior consent. These circumstances include, but are not limited to, the following: a) it comes to the attention of the PC that a serious threat of harm to an identifiable person exists; (b) the PC learns of information suggesting possible abuse or neglect of a child; (c) the PC learns of information indicating clients may pose a danger to self/others or an inability to meet basic needs, (d) information may be released in accordance with and as specified by court order.

I understand that information, records, communications and testimony concerning my family or myself must be disclosed in the event of a court order demanding it. Additionally I understand that information, records, communications and testimony concerning my family or myself may be disclosed in litigation or other proceedings in accordance with the relevant statutes or previously issued court orders. I understand that our coparenting coordinator with HCG may provide documentation which memorialize agreements made during the course of our work together.

Fees for PC services are shown on the HCG fee schedule (www.hawthorncounseling.com). I understand that PC services will be billed at the specified hourly rate, or pro-rated fractions thereof, for any and all time spent regarding my case (examples include: individual or conjoint PC sessions, document preparation, reading/responding to emails or other communications, telephonic consultation, consultation with my attorney). I understand that a retainer of $2,000 is to be provided at the outset of services, to be replenished for that same amount should the retainer be depleted. I agree to give full 24 hours notice when canceling an appointment and, without such notice, I understand that I will be charged one full hourly session fee ($260.00) for any late cancellations or failed appointments. I will furnish HCG a credit card for billing and I give consent to HCG to utilize this account for collection of charges for all services, late cancel/failed appointments and any outstanding balances which may accrue. I understand that HCG will furnish an invoice showing charges and payments at any time upon request. I understand that my health insurance plan cannot be billed for PC services. While both parties to the PC process are asked to execute this consent form, I understand that only one retainer is required, which will be utilized for all services related to my case, whether these are conjoint or individually scheduled PC services. I understand that the parties involved in my case are responsible for determining who and by what amount they will establish and, if necessary, replenish the retainer.

I understand and agree to the information and terms described above and wish to retain the services of HCG for coparenting consultation. I understand that both parties are asked to execute this agreement, separately, in connection with our coparenting coordination case.

Printed name : ____

Signature: ____ Date: __________