Meg O. Lukan M.S.,L.C.P.C.,LLC
2390 Esplanade Drive suite 206
Algonquin, Il 60102
www.meglukan.com
Meglukan@gmail.com
(847)426-2614

Office Policies/Procedures

When you come in for an appointment, please have a seat in the chairs across from the elevator on the second floor. Meg will meet you there at the time of your appointment.

There will not be **any** release, call, email, or relay of information to **any** outside party unless the client signs a release provided by their counselor.

If you need to schedule, change, or cancel an appointment, please call: (847) 426-2614; Or email: Meglukan@gmail.com. A **48-hour** notice of cancellation is required.

New clients over the age of 18 must call in to make their own appointments, clients 12-18 years old must be aware an appointment is being made for them.

If I am between the ages of 12-18 years old, my parents/legal guardian will be given the option to participate In a "Child Safe Harbor" agreement.

If your situation is an emergency and you need immediate attention, please call 911 or go to your closest emergency room!

Please initial:

I have received my notice of privacy practices (NPP)
And my therapist has answered my questions regarding access to important treatment information._____

I acknowledge that Meg O. Lukan M.S., L.C.P.C, is an in-network provider for many insurance plans. However, I acknowledge that it is my sole responsibility to confirm these benefits prior to my initial visit._____

For billing and reimbursement purposes, I give permission to release **CONFIDENTIAL** information to my insurance company. I acknowledge that all co-pays and outstanding balances are due at the time of each visit._____-

I acknowledge that any appointments that are either made through, or conducted by email phone, text or video for my convenience, are currently considered a **NON-HIPAA** approved form of communication. I acknowledge the risk involved with these forms of communication, and agree to use these platforms for messaging appointment reminders, receipt of services rendered, phone/video appointments or general communication with my counselor._____

I would like to,**"OPT-OUT"** of **ALL** the above communication._____

If I participate in phone or video counseling sessions, I agree to providing a local emergency contact person for safety issues that involve danger to myself, or to someone else.

Name:_____ Phone:_____

I acknowledge that a $50.00 **no-show/late cancellation fee** will be billed to me if I do not provide a 48 hour notice of cancellation._____

Electronic communication contact information:

Cell phone/text:_____

Email:_____

Client signature:_____

Date:_____

Therapist signature:_____

Date:_____

Record of Payment: This card will remain on file to bill for all co-pays, deductibles, co-insurance, or out of pocket payment for services rendered.

Cardholder Name:_____

(If you are under 18 years old; and/or other Credit Card Holder's Name:_____

Visa/MC/Amex: (Circle one)

Card Number:_____

V-Number (Important)_____

Exp. Date:_____

Zip Code of Cardholder:_____

Cardholder's email:_____phone:_____

Signature:_____Date:_____