1820 Ridge Road, Suite 303R; Homewood, IL 60430

**Client Information Form**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian (if under 18)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name & Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| May I send correspondence or leave a message?  Home addressYes No  Home phone Yes No  Cell phone Yes No  Email Yes No  \*Please note: Email correspondence is not considered to be a confidential medium of communication | Referred by/ how did you find me?  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| Insurance Information: **please complete if you are using insurance**  Insurance Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PPO/HMO?\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Insured**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured Phone & Address (if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insured ID #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Deductible & Copay amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Phone # for Providers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please indicate if you are using **EAP** and **authorization #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Please fill in the information below and bring it with you to your first session.

Please note: information provided on this form is protected as confidential information.

**Personal Information**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age:\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status:

\_\_Never Married \_\_Domestic Partnership \_\_Married

\_\_Separated \_\_Divorced \_\_Widowed

**History**

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

\_\_No \_\_Yes, previous therapist/practioner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any prescription medication? \_\_Yes \_\_No

If yes, please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been prescribed psychiatric medication? \_\_Yes \_\_No

If yes, please list and provide dates and past diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any psychiatric hospitalizations (If so, please list locations, dates and treatment): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General and Mental Health Information**

How would you rate your current physical health? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health concerns/problems you are currently experiencing:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last PCP visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your current sleeping habits? (Please circle one)

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you generally exercise?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What types of exercise do you participate in?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any difficulties you experience with your appetite or eating problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing overwhelming sadness, grief or depression? \_\_ Yes \_\_ No

Are you currently experiencing anxiety, panic attacks or have any phobias? \_\_Yes \_\_No

Are you currently experiencing any chronic pain? \_\_Yes \_\_No

How often do you engage in recreational drug use or alcohol consumption? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol more than once a week? \_\_Yes \_\_ No

Do you consume recreational drugs more than once a week? \_\_Yes \_\_No

Any current or past participation in any drug rehab programs? (Including NA or AA) \_\_Yes \_\_No

If so, please list dates, locations, frequency and treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you find your treatment to be effective? \_\_Yes \_\_No

Are you currently in a romantic relationship? \_\_ Yes \_\_ No If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of 1-10 (with 1 being poor and 10 being exceptional), how would you rate your relationship? \_\_\_\_

Have there been any significant changes or stressful events you have experienced within the past year? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Mental Health History**

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (e.g. father, grandmother, uncle, etc.)

Alcohol/Substance Abuse yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anxiety yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depression yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Domestic Violence yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eating Disorders yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obesity yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Obsessive Compulsive Behavior yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Paranoia yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Schizophrenia/Schizoaffective yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Suicide Attempts (death by suicide) yes/no \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Information

Are you currently employed? \_\_Yes \_\_ No Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently enjoy your work? \_\_ Yes \_\_ No (Please explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you consider yourself to be spiritual or religious? \_\_Yes \_\_ No

If yes, please describe your faith and if you would like to evaluate during your treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you please describe what you consider to be your strengths?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you please describe you consider to be your weaknesses or areas in need of improvement?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What would you like to accomplish out of your time in therapy?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to Insights Therapeutic Services LLC. This form has been written to give you an awareness and answer any questions you may have as you begin psychotherapy. If at any time you have questions, please do not hesitate to ask me for clarification.

**Arrival**

When you arrive for your appointment please know there is no receptionist to check you in. Your therapist will come to greet you in the waiting room at your appointment time.

**Appointments and Cancellations**

Studies show that most people feel better after they come to therapy. The best results occur when you consistently schedule appointments and maintain regular attendance. Each session lasts approximately 45-60 minutes. All appointments must be scheduled in advance with your therapist or through the ITS portal. If you are receiving counseling services and cancel a session with less than 24 hours-notice or miss a session, you will be personally responsible for a $50.00 cancellation fee. Payment is your responsibility directly since insurance companies do not pay for “no-shows”. In cases of emergency or special circumstances, where 24 hours-notice is not possible, the late cancellation may be waived.

**Children in the waiting room**

We are unable to provide a supervised space for children and will not accept responsibility for their safety if left unattended. However, parents will be financially responsible for any damages to the offices.

**Confidentiality**

Anything discussed in sessions, including case notes and records will be treated as confidential. No information will be disclosed without your written consent as the client or a legally appointed representative unless required by law. **Your therapist is required by law to report any disclosed or suspected child, elder, or dependent adult abuse and any situation where the client threatens violence to an identifiable victim or self.**

**Fees and Payment**

You are expected to pay for professional services at the time of service unless other arrangements have been made with the therapist. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount, **as estimated by your insurance quote of benefits**. If actual payment by your insurer differs from what was expected, a financial adjustment will be made promptly. Currently, acceptable forms of payment are cash or credit/debit card. Whichever form of payment you choose, you will be asked to complete an *Electronic Payment Consent and Authorization Form.*

**How many sessions will I need and when can I end them?**

The best results for success in therapy happen when you schedule and attend weekly appointments. However, every circumstance and individual heal their issues at a different pace. We will work together on a schedule and set goals that you can work on each week that meet your unique needs. If at any time you would like to terminate treatment, we ask that you inform us at least 1 or 2 sessions prior for an appropriate and healthy ending. We will provide you with additional referrals or resources as needed upon termination.

**Contact Information**

Between appointments, you may send a secure message from the portal, voicemail or text message to your therapist. In case of an emergency, you are advised to proceed to the nearest emergency room or to dial 911. Please provide your therapist with your inpatient information when discharged or your follow up appointment.

*I agree to pay for all services provide up until the time the therapy relationship is terminated.* **I have read and understand all of the terms and conditions stated above regarding therapy. All my questions have been answered fully. I understand and agree to the terms and conditions of this agreement.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature

(12 years and **older**) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature

(Couples/Family Counseling) Date

**Consent for treatment of children or adolescents:**

I/We consent that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of Child) may be treated as a client. My signature below indicates that I have read and understand the information provided in this document and agree to abide by its terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent/Guardian (for all children up to 18 years of age) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of

(for children up to 18 years of age) Date

**ELECTRONIC PAYMENT CONSENT AND AUTHORIZATION FORM**

Please complete the following information. **Charges to your card will be listed on your statement under Insights Therapeutic Services LLC or an abbreviation or variation of such**.

CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARDHOLDER INFORMATION:** (Please indicate the exact name and address associated with the credit or debit card you wish to use.)

Name as printed on card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_\_\_\_\_

**I authorize Insights Therapeutic Services LLC to use the information below to charge my credit/debit card ending in \_\_\_\_\_\_\_\_\_\_\_\_** (provide the last four digits of the card) **for professional services as follows:**

* 🞏 A one-time charge in the amount of $\_\_\_\_\_\_\_\_\_\_\_ for services on \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_.
* 🗹 Recurring charges for services in the amount of $\_\_\_\_\_\_\_\_\_\_\_ per session.
* 🗹 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_$50 cancellation fee when applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* 🗹 I understand and agree that my card will be charged if my check is returned for any reason.
* 🗹 I understand and agree that my card will be charged if I do not pay any balance due to Insights Therapeutic Services left by client, client’s insurance company, or any third-party payer.
* 🗹 I understand this authorization form is valid for one year unless I cancel the authorization in writing. **I will not dispute charges for sessions client has attended or appointments missed or late-cancelled according to the above policy. I understand that I am responsible for updating this credit card information whenever it changes.**

**CARDHOLDER SIGNATURE**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **CREDIT/DEBIT CARD INFORMATION:**

Please provide your payment information below. This information will be stored securely and the card information you provide on this form will be used until updated or modified.

CARD TYPE: ❒Visa ❒MasterCard ❒Discover ❒Amex

CARD NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SECURITY CODE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT**

By entering into therapy, we have begun a professional relationship with financial implications. Financial matters are extremely important to all of us. We welcome your questions and comments regarding my financial policies, to reduce any chance of misunderstandings or difficulties.

**Fees:** Your therapy sessions will be billed at a rate of $150. For sessions scheduled or run over time will be billed at a rate of $175 per 75-90 minute session. Group and workshop rates vary.

If you are utilizing insurance benefits and we are an **in-network** provider, these fees will be reduced by the insurer and subject to deductible and coinsurance variables. If you are utilizing insurance benefits and we are an **out-of-network** provider, these fees will be varied by the insurer. Occasionally, my hourly fees must be raised to cover increased expenses. We will give you notice prior to any increase.

**Payment:** You are expected to pay for services at each session. If you are utilizing insurance benefits, you are expected to pay your deductible, co-pay or coinsurance amount, as estimated by your insurance quote of benefits. If actual payment by your insurer differs from what was expected, a financial adjustment will be made promptly. Currently, acceptable forms of payment are credit/debit card (VISA, MasterCard, or Discover), cash, or check (payable to Insights Therapeutic Services). Whichever form of payment you choose, you will be asked to complete an *Electronic Payment Consent and Authorization Form*. Please be aware that **you** – not your insurance company – are responsible for full payment of the fee that we have agreed to. If for any reason your plan does not cover the services provided, or covers them at a different level than was originally understood, you are responsible for full payment of fees.

**Cancellation Policy:** We maintain a standard 24-hour cancellation policy. Your appointment time is reserved exclusively for you. If you need to cancel or reschedule an appointment, please inform us as soon as possible, but at least twenty-four (24) hours in advance to avoid **$50 cancellation charge**. For such purposes, we require your signature and a credit card number on file. You may call or send a text message at any time when you realize that you will not be able to make your scheduled appointment.

Other circumstances in which your card may be charged are (1) if a check is returned for any reason, or (2) if there is any unpaid balance due after your insurance (if you are using insurance) or any third-party payer has considered all claims.

**Documentation**

There are times you may need documentation for other providers and/or your employer. Please inform your therapist as soon as possible to allow for a detailed discussion of your needs. It is the standard of Insights Therapeutic Services LLC that appropriate time is allowed to build a relationship with your therapist before paperwork is considered. Due to the time commitment and complexities of documentation (ie. FMLA paperwork) there will be a $40 charge assessed for each request. Please allow 5-7 days for completion.

**Telephone consultations:** A phone consultation is a mutually agreed upon appointment by phone, in an emergency or when unusual circumstances preclude our meeting face to face. Calls that last 15 minutes or more will be charged the regular hourly rate prorated by the quarter-hour. Please note that insurance does not pay for telephone consultations. We will not charge you for a phone call without your consent.

**Signature:** Your signature below indicates that you have read and understand the information provided in this Financial Policy and agree to abide by its terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (or Financially Responsible Parent/Guardian) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (Couples/Family Counseling) Date

**POLICY ON LEGAL PROCEEDINGS**

Insights Therapeutic Services LLC (ITS) will assist clients in certain legal matters should the client request it or if a judge subpoenas the therapist. These legal proceedings are often related to a personal injury, divorce, child custody or criminal matters. Prior to ITS being deposed or testifying in court on behalf of a client, the client must agree in writing to waive his/her right to confidentiality. By doing so, the client is allowing his/her records to be reviewed and scrutinized by non-clinical persons involved in the legal case. Additionally, it is understood that a therapist’s testimony may not always work in favor of the client’s case.

Court and legal proceedings are very time consuming and may require preparation by the therapist. Due to this, there are fees allotted to each type of legal involvement, which are due PRIOR to the service. If the therapist is asked or required to appear for a deposition, the client is required to pay $700.00 at least 96 hours prior to the deposition. This fee covers three (3) hours of time in a deposition and one (1) hour of travel. If the deposition and travel equate to more than four (4) hours of the therapist’s time, the client will be billed at the rate of $125.00 per hour including any time the therapist needs to review your file and prepare for the deposition.

If the therapist is asked or required to appear in court, the client will be required to pay $1,000.00 at least seven (7) days prior to the court appearance. This fee represents an eight (8) hour day. The client will be billed at the rate of $125.00 per hour for any time over eight (8) hours spent by the therapist for travel, preparation, waiting, or to testify in court.

I have read the above policy and hereby agree to the terms of payment and confidentiality:

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Client Signature Date

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Witness Signature Date

**NOTICE of PRIVACY PRACTICES**

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice describes our policies related to the use of your care. We are required to give you this notice about the use and disclosure of your health information, our legal responsibilities and your rights concerning your health information.

# **Your Rights**

Your rights regarding your health information:

1. You have the right to inspect and request a copy of your information with limited exceptions. Your request must be in writing and if you request a copy a reasonable charge may be made for the costs incurred.
2. You have the right to request to amend your health information. The request must be in writing and it must explain why the information should be amended. We have the right to deny the request in certain circumstances.
3. You have the right to request an accounting disclosure, which is a list of instances in which we have disclosed your information for a purpose other than treatment, payment, or health care operations. The request must be done in writing.
4. You have the right to request restrictions or limitations on health information we use or disclose about you with some limitations. This is not applicable if you choose to use your insurance provider to cover treatment costs.
5. You have the right to request confidential communications by asking us to contact you in a reasonable manner.

**Questions and Complaints**

If you believe your privacy rights have been violated, you may file a complaint with us, or you may file a complaint with the U.S. Department of Health & Human Service. We will not retaliate against you for filing a complaint.

**Use and Disclosure of your health information**

We use and disclose the minimum necessary health information about you for your treatment within our practice, for payment for your services to your insurance carrier, and for our internal operations to tell you about services or educational activities that may be of interest for you. If you wish for an outside health care provider to obtain your health information, we will obtain a signed authorization from you in order to provide this information first.

**Information Disclosed Without Your Consent**

Under Illinois and Federal Laws information about you may be given without your consent in the following circumstances:

* Emergencies: sufficient information may be shared for an immediate emergency you are facing
* Judicial and Administrative Proceedings: We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process.
* Public Health Activities: if we felt you were in immediate danger to yourself, or others we may disclose health information about you to the authorities, as well as alert any other person in danger.
* Child/Elder Abuse: with suspicion of child and/or elder abuse or neglect
* Criminal Activity or Danger to Others: If a crime is committed on our premises or against our personnel or if believe someone else is in danger
* National Security, Intelligence Activities, and Protective Services to the President and Others: We may release information about you to federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.
* Health Oversight Activities: This may include audits, inspection that are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements.
* Business Associates: We may disclose minimum health information necessary to our business associates that perform functions on our behalf or provide us with services if necessary such as financial audits. All of our business associates sign agreement to protect the privacy of your information and are not allowed to use or disclose any information other then as specified in our contract.
* Marketing: We may send you newsletters or information about services we provide in which we feel you might be interested. You may at any time request that your name be removed from our mailing list. We will not disclose any information to a third party for their use in telemarketing, direct mail marketing, or marketing through electronic mail
* Scheduling Appointments: We may use your phone number to text you, call you and leave message to schedule or remind you of appointments.

Any uses and disclosures not set out in the information above will be made only with your written authorization. You may revoke a written authorization for release of information at any time. The revocation must be done in writing and will become effective when it has been received by us, and will only be for disclosures not already completed.

We reserve the right to change our privacy practices provided such changes are permitted by law and make a new notice available to you. Beginning June 1, 2013 we are required to abide by the terms of this notice.

Insights Therapeutic Services LLC

1820 Ridge Road, Suite 303R

Homewood, IL 60430

**Written Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge receiving a copy of the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act.

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Signature of Client Date

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Signature of Client (Significant other) Date

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Witness Date