Center for Authentic Living INC
120 Main St. Ste. 200
Park Ridge, IL 60068

Client Intake Form

Patient (receiving service)		Primary Insurance Holder	
First Name:		**First Name:**	
Last Name:		**Last Name:**	
DOB:		**DOB:**	
Gender:		**Gender:**	
Address:		**Address:**	
City:		**City:**	
State:		**State:**	
Zip:		**Zip:**	
Phone #		**Phone #**	
Email:		**Email:**	
Referred by:		**Relation to Patient:**	

Insurance Information	
Insurance Company:	
Plan Type (PPO, HMO, Other):	
Subscriber ID:	
Group Number:	
Claims Address:	

Credit Card Information	
Cardholder Name:	
Cardholder Email:	
Card Type:	Credit ☐ Debit ☐ HSA ☐
Card Number:	
Expiration Date:	
Security Code:	
Zip Code:	
Cardholder Signature:	

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Informed Consent

Clinician Name:

Client Name:

_____I hereby authorize the psychological treatment and/or evaluation of myself, or my dependent, by the above-named clinician at Center for Authentic Living. I have discussed stated goals of psychological treatment and/or evaluation and I understand that I have the right to ask my therapist for information regarding diagnosis, goals for treatment, and estimated length of treatment.

_____I understand that if a therapist agrees to provide services to multiple people who have a relationship (such as spouses, significant others, parents and children), reasonable steps are taken to clarify at the outset (1) who the patient is and (2) the relationship the clinician will have with nonpatients.

_____I understand that personal notes taken by my therapist represent personal work product and are the property of the therapist and/or Center for Authentic Living. I also understand and agree that my therapist may properly retain such documents in my file according to professional standards.

_____I understand that the therapist is not required to release personal notes about my care, since the notes represent personal work product, and are not part of the formal record. Typewritten reports about my care can be sent out if provided with proper written authorization, and this will be done according to professional standards.

_____I have been informed of the procedure for contacting my therapist and I understand the policy regarding cancellations and missed appointments.

_____I understand that this agreement becomes part of my record, which is accessible to the parties at will, but to no other person without written consent.

_____I understand that the clinician will respect my right to maintain confidentiality of information communicated by me or obtained from me during the treatment period. I understand that there are legal limitations of such confidentiality (i.e., cases of suspected child or elder abuse, fear of danger to self or others, or if information is ordered released by Court Order).

Signature of Client or Legal Guardian: _____

Date

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Fee Agreement

Clinician Name:

Client Name:

_____I agree to pay in full for all services provided to me at Center for Authentic Living.

_____I understand and agree that I am responsible for any charges that are not covered by insurance or any other third-party payor.

_____I agree to assist my clinician in submitting claims for insurance reimbursement.

_____I agree that payment of insurance benefits be made directly to Center for Authentic Living. I authorize the release to insurance companies any information requested by them to determine their liability for claims submitted to them for reimbursement. This agreement covers the entire period of my relationship with my clinician.

_____I understand that copay, coinsurance, and deductibles must be paid at the time of service or when Center for Authentic Living receives an explanation of benefits in the mail.

_____I understand that I will receive an explanation of benefits in the mail for each service date.

_____I understand that providing a credit card to be put on file at Center for Authentic Living, means I will be **automatically** charged on a weekly basis for any balance due from (including but not limited to) copays, coinsurance, deductibles, self-pay fees, and no-show fees.

_____I understand that if I pay for any services or fees using cash or check, I must give it to my clinician in person, or mail it to Center for Authentic Living.

_____I understand that if I do not make payment for any services or fees, I will be invoiced within 2 months.

_____I understand that credit cards will be charged a 2.5% processing fee while debit cards and HSA cards will not be charged any fees.

_____I understand that there will be a $20.00 fee for any returned checks.

_____I understand that there is a $90.00 cancellation fee for not showing up to appointments and for cancelled appointments in less than 48 hours.

_____I understand that the credit card I leave on file will be charged for any balance due after 2 months.

Signature of Client or Legal Guardian: _____

Date

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Electronic Communication Policy

Clinician Name:

Client Name:

_____I understand that my clinician will keep my communications confidential by use of passwords, locks on file cabinets, and by making use of encryption technology.

_____I understand that Center for Authentic Living, Inc. uses an encrypted email service to communicate ePHI.

_____I understand that free email services, text messaging, voice messaging, video chats, and other instant messaging services are not encrypted and therefore ePHI should not be communicated through these services.

_____I understand that when I choose to communicate PHI electronically with my therapist (including but not limited to email, text message, voice message, video chat, instant messaging) I am breaking confidentiality under the Health Insurance Portability and Accountability Act (HIPAA).

Signature of Client or Legal Guardian: _____

Date

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Type of Card: **(Debit, Credit, HSA)**
Cardholder Name:
Cardholder Email:
Card Number:
Expiration Date (mm/yy):
ZIP Code:
Security Code:

I, _____, authorize CENTER FOR AUTHENTIC LIVING INC, to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date