

Intake Date:

Internal Use Only:

Initial Intake Forms

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

Copay:

Coinsurance:

Deductible:

Phone: (847) 720-4773
Billing: (847) 282-0225
Fax: (847) 728-5313

PATIENT/CLIENT INFORMATION:	PRIMARY INSURED/GUARANTOR INFORMATION:
Patient's Name: _____	Insured Name: _____
Patient's Birthdate: _____	Insured's Birthdate: _____
Address: _____	Address: _____
City: _____ Zip: _____	City: _____ Zip: _____
Home Phone: _____	Home Phone: _____
Cell: _____	Cell: _____
Email: _____	Email: _____
Referred by: _____	Insured Employer: _____
Gender: _____	Gender: _____

Insured relationship to Patient: SELF Parent/Guardian Spouse/Partner Other

INSURANCE COMPANY INFORMATION

Name of Insurance Company and Plan: _____

Insured ID # (Include Alpha Prefix): _____ Insured Group Policy #: _____

Insurance Phone Number: _____

CREDIT CARD Cardholder Name: _____

CARD TYPE: VISA MC AMEX DISC HSA DEBIT Zip Code: _____

Card # _____ Expiration Date: _____ Security Code (3 or 4 digits): _____

Cardholder signature authorizing charges on the credit card: _____

***Note: Missed appointments without proper notice will result in a \$100.00 no-show fee.

Who is the patient's primary physician, psychiatrist, or other practitioner?

Name: _____

Please list any current or past medications with dosage:

Phone Number: _____



Fees:

60 min. Initial Assessment \$175

60 min. Individual Therapy \$150

Letter Writing \$75

Fee Agreement

Do you agree to have your insurance billed for therapy? Yes. No.

Do you agree to pay **without using insurance** (self-pay)? Yes. No.

Did you leave a credit card on file to be billed if applicable? Yes. No.

Please acknowledge the following by checking the box:

A credit card on file is required to schedule appointments if you are subject to a fee.

Failure to cancel an appointment within 24 hours or failing to show for an appointment will result in a \$100 No-Show or Late-Cancel fee.

The credit card on file will be billed for copay/coinsurance/deductibles if applicable.

The credit card on file will be billed for a "self-pay fee" if not utilizing insurance.

Outstanding balances over 90 days will be sent to collections.

If your balance reaches \$100 you will be required to provide a credit card on file in order to continue service.



Electronic Communication Policy

- 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 the Center for Authentic Living 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 clinician (including but not limited to free email, text message, voice message, video chat, instant messaging) I am breaking confidentiality under the Health Insurance Portability and Accountability Act (HIPAA).



Informed Consent

Therapist Name: _____

I hereby authorize the psychological treatment and/or evaluation of myself, or my dependent, by the above-named therapist 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 therapist will have with non patients.

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 therapist 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 Patient/Legal Guardian: _____

Date: _____

Print Patient Name: _____



PERMISSION FOR RELEASE OF INFORMATION

THE UNDERSIGNED HEREBY GRANTS PERMISSION TO:

Mental Health Service Provider: Center for Authentic Living
Address: 120 Main St Ste 200
Park Ridge, IL 60068
Telephone: (847) 668-4869

TO DISCLOSE TO **AND/OR**

OBTAIN INFORMATION FROM:

Name of agency or individual _____
Address: _____
Telephone: _____
Fax: _____

INFORMATION TO BE DISCLOSED/OBTAINED (in written or verbal form):

- | | |
|---|---|
| <input type="checkbox"/> Initial Interview/Intake Summary | <input type="checkbox"/> Assessment Report |
| <input type="checkbox"/> Attendance Record | <input type="checkbox"/> Test Results |
| <input type="checkbox"/> Progress Reports | <input type="checkbox"/> Incarceration Records |
| <input type="checkbox"/> Discharge/Closing Summary | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Observations/Recommendations | <input type="checkbox"/> Critical Incident Report |
| <input type="checkbox"/> Performance Review Summary | <input type="checkbox"/> other _____ |

THIS PERMISSION IS GRANTED IN ORDER TO:

- obtain necessary information for an assessment
- facilitate continuity of care among health care providers
- permit case management
- enable employer to make determination of employment status
- support a multi-systemic treatment approach
- other _____

EXPIRATION: This permission will expire one year after the Undersigned terminates services with the Health Service Provider or until revoked in writing by the Undersigned prior to that date.

Patient's name

Patient date of birth

Patient signature
(Or parent/guardian signature if minor)

Date of signature

Witness signature

Date of signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 C.F.R., Part 2) prohibits you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of this information is not sufficient for this purpose,



CENTER FOR AUTHENTIC LIVING
INTEGRATIVE MODALITIES FOR HEALTH WELLNESS AND RECOVERY

Authorization to Release Information in Case of Emergency

I, _____ hereby authorize, _____ ,
to contact my emergency contact (listed below) in the case of injury or illness that occurs during session,
and I am unable to call for help. I acknowledge that the individual above will be authorized to release
medical information to this individual only in the case of injury or incapacitation.

I authorize _____ to call my emergency contact and preform a wellness check-
up and ask about my condition under the condition I have endorsed suicidal ideation or displayed
concerning behavior in group; only under the condition, that I have endorsed the previous statement, I
have not shown up for group, and I have not contacted the therapist to inform her I will be missing or
have not reposed to communication attempts. I acknowledge that _____ will not reveal
any information about my mental health, medical records, treatment plans, or divulge personal details to
this individual, and will only inquire about my physical wellness.

If emergency service needs to be contacted due to illness, injury, or for situations as demanded by
law, I authorize _____ to inform medical services of any current medical conditions
and medications, if I am incapacitated or unfit to do so.

I also understand that I have a right to receive a copy.

I understand that I have the right to change who my emergency contact is and revoke previous
authorizations.

I understand that I have the right to revoke this authorization at any time.

I understand that I have the right to refuse authorization or release of information.

This Authorization shall remain valid until: _____

A photocopy of my signature is as valid as the original.

Patient's Signature: _____

Date: _____

Emergency Contact Name: _____

Relationship: _____ Phone Number: _____