Intake Date:

Internal Use Only:

Copay:

Coinsurance:

Deductible:

Initial Intake Forms

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

Phone: (847) 720-4773
Fax: (847) 728-5313

PATIENT/CLIENT INFORMATION:

Patient's Name: ___________________________________

Patient's Birthdate: ________________________________

Address: ____

City: ________________________ Zip:_______________

Home Phone: ______________________________________

Cell: __________________________________

Email: ____

Referred by: ______________________________

Gender:

PRIMARY INSURED/GUARANTOR INFORMATION:

Insured Name: ____

Insured's Birthdate: _____________________________________

Address: ____

City: ___________________________ Zip: _________________

Home Phone: ____

Cell: ______________________________________

Email: ____

Insured Employer: ______________________________________

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:

Phone Number:

Please list any current or past medications with dosage:

CENTER FOR AUTHENTIC LIVING
INTEGRATIVE MODALITIES FOR HEALTH WELLNESS AND RECOVERY

Fees:
60 min. Individual Therapy $150
60 min. Initial Assessment $175
Letter Writing $75

Fee Agreement

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

☐ Do you agree to be self-pay (not utilizing insurance)? Yes. No.

☐ Are you going to leave a credit card on file so that patient payments can be auto-charged weekly? Yes. No.

☐ Are you going to bring your credit card (or a check) in person to each appointment to pay at the time of service? Yes. No.

I understand that failure to cancel an appointment within 24 hours will result in a $100 no-show fee.

I understand that both parties must be present for a couples session to be rendered. If one party is not present then that will result in a $100 no-show fee.

I understand that my credit card on file will be billed for copay/coinsurance/deductibles if applicable.

I understand that my credit card on file will be billed for self-pay if applicable.

I understand that I will receive an invoice for any outstanding balances.

I understand that there will be a $20 fee for returned checks.

I understand that if I do not leave a credit card on file, then I must bring my credit card (or a check) into each session to pay at the time of service.

I authorize my credit card to be billed for copay/self-pay and any balance due up to 6 months after my appointment(s).

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).

CENTER FOR AUTHENTIC LIVING
INTEGRATIVE MODALITIES FOR HEALTH WELLNESS AND RECOVERY

Informed Consent

☐ 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: ______________________

CENTER FOR AUTHENTIC LIVING
INTEGRATIVE MODALITIES FOR HEALTH WELLNESS AND RECOVERY

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):

☐ Initial Interview/Intake Summary
☐ Attendance Record
☐ Progress Reports
☐ Discharge/Closing Summary
☐ Observations/Recommendations
☐ Performance Review Summary
☐ Assessment Report
☐ Test Results
☐ Incarceration Records
☐ Medical Records
☐ Critical Incident Report
☐ 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 Date of signature
(Or parent/guardian signature if minor)

___________________________________ ___________________________________
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,

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: _______________________