

Initial Intake Forms

Center for Authentic Living

120 Main St. Ste. 200
 Park Ridge, IL 60068
 Phone: (847) 668-4869

| 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 | <i>(We do not accept HMO plans, Medicaid or Medicare.)</i> |
|--|--|
| Name of Insurance Company and Plan: _____ | |
| Insured ID # (Include Alpha Prefix): _____ Insured Group Policy #: _____ | |
| Copay: _____ | Coinsurance: _____ Deductible: _____ |

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: Canceled appointments after 48 hours are subject to \$75.00 fee and no-show no-calls are subject to a \$150.00 fee. |

| Who is the patient's primary physician, psychiatrist, or other practitioner? | |
|--|--|
| Name: _____ | Please list any current or past medications with dosage: _____ |
| Phone Number: _____ | |

Do you have secondary insurance? If so, please list the information here and include a copy of the secondary insurance ID.

Secondary Insurance Name: _____

Secondary Insurance ID & Group # _____

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BILLING 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? Yes. No.

| | |
|-------------------------|---|
| <u>Payment Options:</u> | <u>Using Insurance Service Fees:</u> |
| Cash/Check | 60 Min. Initial Consultation \$300.00 (Billed to Insurance) |
| Zelle | 60 Min. Psychotherapy \$275.00 (Billed to Insurance) |
| Credit Card | <u>Not Using Insurance Service Fees:</u> |
| Debit Card | 60 Min. Initial Consultation \$200.00 (Billed to Client) (Self-Pay) |
| | 60 Min. Psychotherapy \$175.00 (Billed to Client) (Self-Pay) |

| | |
|----------------------------|--------------|
| <u>Other Fees:</u> | |
| No-Show/Late-Cancel | \$150.00 |
| Billing Service Fee | 3.75% |

The billing service fee will be applied for the use of credit cards. If you would like to avoid that, please pay with cash/check or Zelle.

Please acknowledge the following by checking the box:

Clients with HMO, Medicaid or Medicare plans we do not accept are subject to the self-pay fee.

Cancellation Policy - Clients must provide 48 hours notice to cancel an appointment. Appointments canceled with less than 48 hours notice will be charged a \$75.00 late cancel fee. Failure to show up for an appointment aka no-show no-call will result in a \$150.00 no-show 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 unless otherwise specified.

If your balance reaches \$100+ you will be required to make a payment in order to continue service.

To avoid the billing service fee, please pay with cash/check or via Zelle (847) 668-4869.

Signature:

Date:

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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 Center for Authentic Living uses an encrypted email service to communicate PHI internally between staff.
- I understand that free email services, text messaging, voice messaging, video chats, and other instant messaging services are not encrypted and therefore PHI should not be communicated through these services.

While we utilize encrypted HIPAA compliant electronic/video transmission software to deliver telehealth and electronic, we cannot ensure the confidentiality of any form of communication through electronic media, including but not limited to email, text message and video teletherapy (hereinafter collectively referred to as "tele".) If you prefer NOT to communicate via tele, please inform your provider.

If you and your provider choose to use tele for some or all your treatment, you need to understand that:

- 1. You retain the option to withhold or withdraw consent verbally or in writing at any time without affecting the right to future care or treatment or risking the loss of withdrawal of any program benefits to which you would otherwise be entitled.**
- 2. All existing confidentiality protections are always equally applicable. Dissemination of any of your identifiable images or information from the tele interaction to researchers or other entities shall not occur without your consent.**
- 3. All services provided via tele will be billed in accordance with your fee or insurance arrangement.**

Signature:

Date:

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Client Consent for Service Form

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: _____

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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) 720-4773

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,

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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: _____