The Center for Collaborative Counseling & Psychiatry

2250 Point Blvd Suite 140
Elgin, IL 60123
P: 847-214-3651 F: 847-214-3669

Client Information Sheet

Date: _____

Name: _____
First Middle Last

Date of Birth: _____ **SS#**: _____

Home Address: _____
Street PO Box

_____
City State Zip Code

Home Telephone: ( ) _____ **Work:** ( ) _____

Cell Phone: ( ) _____ **Email:** _____

Sex: ☐Male ☐Female ☐Transgender

Race: ☐White ☐Black ☐Indian ☐Asian ☐Hispanic ☐Other

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Domestic Partners

Employment Status: ☐Unemployed ☐Employed ☐Student ☐Retired ☐Homemaker

Military Status: ☐Yes ☐No Highest Grade Completed: _____

Primary Language: ☐English ☐Sign Language ☐French ☐Spanish ☐Other

Living Arrangement: ☐Private Residence ☐Other _____

Emergency Contact Name: _____**Relationship**_____

Home Telephone: ( ) _____ **Work ( )** _____

Legally Responsible Person (if client is child) _____
Name Relationship

Home Telephone: ( ) _____ **Work ( )** _____

Counseling Issues: (place a check next to the areas you wish to discuss)

__Relationship issues	__health concerns	__death/loss of sign. Other
__Racial issues	__suicidal thoughts	__family problems
__Cultural adjustment issues	__career concerns	__divorce/separation
__Stress	__anxiety	__domestic violence
__Depression	__loss of employment	__trauma
__Lack of assertiveness	__low energy	__sexual/physical abuse
__Alcohol/drug abuse	__sleeping problems	__legal issues
__Development/self-esteem	__religious/spirituality	__parenting issues
__Sexuality	__marriage concerns	__eating concerns

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REFERRED BY: _____

How much are the issues checked above disrupting your life?

☐A minor disruption ☐somewhat of a disruption ☐an overwhelming disruption

Have you ever participated in counseling of any type?

☐Yes ☐No

Have you ever been hospitalized for a psychiatric problem?

☐Yes ☐No

Have you experienced any type of health problems over the last 2 years?

☐No ☐Yes—please explain: _____
_____

Are you currently in the middle of a crisis?

☐No ☐Yes—please explain: _____
_____

Are you feeling suicidal? ☐No ☐Yes, with thoughts only ☐Yes, with a plan

Do you want to hurt someone? ☐No ☐Yes, with thoughts only ☐Yes, with a plan

Do you have friends? ☐None ☐few ☐many

Do you have someone you can talk to about personal problems? ☐Yes ☐No

Are you on any medications?

☐No

☐Yes, please list name, dosage, and prescribing physician:

MEDICATION	DOSAGE	PHYSICIAN

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INSURANCE, PRIMARY CARE PHYSICIAN, AND REFERRING PSYCHIATRIST AUTHORIZATION

I understand that if therapy is being paid for using insurance, The Center of Collaborative Counseling & Psychiatry will release any and all records pertaining to treatment to the insurance company, the primary care physician, or to your referring psychiatrist electronically, or by mail if such disclosure is necessary for claims processing, case management, coordination of treatment, or utilization review purposes. I hereby authorize payments for medical services rendered to myself to be made wither to me or on my behalf to CCCP. I understand that I am responsible for any amount not covered by my insurance.

Client's Signature: _____ Date: _____

Insured's Signature: _____Date: _____

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OFFICE POLICIES, GENERAL INFORMATION &
CONSENT FOR TREATMENT FOR PSYCHOTHERAPY SERVICES

Welcome to The Center of Collaborative Counseling & Psychiatry and thank you for choosing us. Please carefully read the following information because it will help you utilize our services most effectively. Feel free to ask any questions. This document contains important information about our professional services, business policies, and the current legal and ethical requirements for all of the licensed clinicians at The Center of Collaborative Counseling & Psychiatry.

Please initial next to each paragraph:

_____ **HIPPA CONSENT FORM:** I have read the Collaborative Counselling "Notice of Policies & Practices to Protect the Privacy of your Health Information" (also known as "HIPPA Consent") form either on our website, or the posted form in the office and understand that it describes how psychological and medical information about me may be used or disclosed and how I can gain access to this information. In addition, I understand that I am welcome to a copy of this HIPPA Consent form if I simply request it from my doctor or therapist.

_____ **CONFIDENTIALITY**: The information you share with us is confidential; that means that information about you does not leave our office without our consent or authorization. Exceptions to this policy are outlined more fully in the HIPAA Consent Form. Briefly, information may be disclosed only by if the following criteria are met or are necessary:

- Diagnosis and date of service shared with your insurance company (if insurance is billed for treatment purposes)
- Mandated reporting of physical or sexual abuse of children
- Threats of suicide or homicide
- Cases where you have signed a release of information for information to be disclosed
- Information released as outlined in the HIPPA Consent Form

In addition to the above, we sometimes consult with professional colleagues to improve the quality of care we provide. Your signature on this form constitutes advance consent for this practice. We do not use names or other identifying information when discussing "cases" with other professionals. They are also bound to keep this information confidential. We have an office assistant who has access to files, and she has signed a confidentiality agreement. We follow HIPPA procedures re: transportation of files. Records containing information about your visits are stored in a locked file cabinet.

_____**CULTURAL COMPETENCE:** The Center of Collaborative Counseling & Psychiatry, prohibits discrimination on the basis of race, color, national origin, age, disability, sex, marital status, familial status, parental status, religion, sexual orientation, or political beliefs.

_____**EMERGENCIES**:

*** Outside of session:** If there is an emergency while you're a client where your therapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, he/she will do whatever he/she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. He/she may also contact the person whose name you have provided as your emergency contact on the Personal Data sheet. We are not available for after-hours emergencies. If you feel that you cannot safely wait for us to return your call, you should call your physician, go to or call the local emergency room, or call 911.

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*** Inside of session:** Your therapist may also disclose your PHI (Protected Health Information) to others without your consent if you are incapacitated or in an emergency. For example, if you are in session with your therapist and begin to experience an anxiety attack, your therapist will not assume that it is anxiety-based, and may call for emergency medical treatment to insure that nothing more serious is happening for you medically.

_____ **FINANCIAL ASPECTS OF CONTRACTING PSYCHOTHERAPY SERVICES**:

*** Insurance Reimbursement:** We will file insurance claims for you, and provide a receipt for payment for personal tax purposes. If your insurance plan has an unmet deductible or the claim is denied for service, you are responsible for payment. We encourage you to contact your insurance company to answer questions you may have about the extent to which our fees are reimbursable. We ask that you authorize payment of medical benefits directly to The Center of Collaborative Counseling & Psychiatry, . We may use and disclose medical information about you so that the services received may be billed and payment may be collected. Please also understand that we may tell your health plan about the treatment you will receive in order to obtain prior approval and determine whether your plan will cover the proposed treatment.

*** Payment for Services (non-insurance):** The fee in working with the psychiatrist, APN or therapist is as follows:

*$150--Individual Therapy or Marital/Family

***Payments Due at Time of Service**: Clients are expected to pay the standard fee per 55-minute session at check out. Please notify your therapist before your session if any problem arises regarding your ability to make timely payments.

SERVICES ASSOCIATED WITH LEGAL ISSUES AND/OR COURT PROCESS

***Fees & Payment regarding legal services**:

Requested documentation and court appearances including travel time, are $150.00 per hour. You should discuss with your therapist before sending a subpoena, because he/she will not often agree to appear in court and may be expected to refuse to give a professional opinion in court. The client or parent whose attorney issues the subpoena must pay $500 in advance of a court appearance, which will be refunded if he/she is notified in a timely manner that the appearance is not needed.

_____THE **PROCESS OF THERAPY/EVALUATION**:

*** Participation** in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly to insure that your therapy is progressing toward your original goal(s).

*** Risks:** During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a

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positive decision for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift; but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results.

* **Theoretical Orientation:** During the course of therapy, your therapist is likely to draw on various psychological approaches according, in part; to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, existential, family systems, developmental (adult, child, family), psychodynamic, or psycho-educational therapy.

_____BOUNDARIES **WITHIN THERAPY**:

* **Phone Calls/Voice-mail & Emergencies**:
Given that we spend majority of our time in sessions, we are often not available by phone. When we are unavailable, the phone is answered by the office manager or voicemail. We monitor our voicemail frequently. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. You may also contact us via email at mpgara@att.net as we check email a few times a day. Emergency appointments can be made during regular business hours, and we will make every effort to accommodate this need.

* **Termination**: Your therapist requests a two-week notice before therapy is terminated to process gains made during treatment, as well as issues to be addressed in the future either by him/her or another therapist.

* **Dual Relationships**: The phrase "dual relationship" is used by the Illinois State Board of Professional Regulation to describe when a therapist is not only serving a client in counseling, but also have a second point of contact, such as serving on a board together, or attending the same book study, etc. Not all dual relationships are unethical or avoidable. Some non-sexual dual relationships are unavoidable and rare examples can be clinically beneficial. Therapy never involves sexual or any other dual relationships that impair your therapist's objectivity, clinical judgment and therapeutic effectiveness; this could be exploitative in nature. Your therapist will assess carefully before entering into non-sexual and non-exploitative dual relationships with clients, discuss with each client the potential benefits and difficulties that may be involved in relationships and will discontinue the dual relationship if he/she finds it interfering with the effectiveness of the therapeutic process. In addition, if you encounter your therapist in any public setting, he/she will never approach you or even acknowledge you unless you first initiate contact so that he/she may protect your confidentiality and the nature of your professional relationship.

_____ **GRIEVANCES**:

If you are dissatisfied with any aspect of our work, please talk with us about it. If you think you have been treated unfairly or unethically, and we cannot resolve the problem, you can contact the Illinois State Board of Professional Regulation for clarification of clients' rights as I've explained them to you or to lodge a complaint.

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I have carefully read, understand, and agree to comply with the above Office Policies, General Information, and Consent for Treatment for psychotherapy services with The Center of Collaborative Counseling & Psychiatry,

_____	_____	_____
Client Name (print)	Signature	Date
_____	_____	_____
Client Name (Print) *(If more than one client)*	Signature	Date
_____	_____	_____
Therapist Name (Print)	Signature	Date

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Informed Consent

I have read The Professional Disclosure Statement and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I understand that I may revoke this consent at any time by submitting written notice of such revocation except to the extent that based on this consent has already been taken.

Client Name (please print) _____

If client is a minor, name of legal guardian: _____

Client's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____

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Credit Card Authorization Form

Card Holder's Name:_____
(Exactly as it appears on the credit card)

Client's Name:_____Therapist:_____

Card Type (circle one): VISA MC AMEX DISCOVER

Card Number:_____ Expiration:_____

CVV Code (3/4 digits only)_____

Billing Address: _____

_____

Card Holder's Phone Number: ( )_____-_____

I authorize the purchase of services from Collaborative Counseling & Psychiatry using this Credit Card Authorization Form. I understand that Collaborative Counselling & Psychiatry may charge my card at any time for services rendered and for the subsequent outstanding balance that may occur. I also understand that if my bill becomes 90 days past due the full-owed amount will be charged to this credit cart automatically. I agree that I will pay for this purchase and indemnify and hold Collaborative Counseling & Psychiatry harmless against any liability pursuant to this authorization. I understand that my signature on this form will serve as authorized signature on the credit card charge slip.

Card Holder's Signature:_____ Date:_____

Witness Signature:_____Date:_____

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DATE: _____

Insurance Coverage Worksheet

Client Name: _____ ID#: _____

Date of Birth: _____ SSN: _____

Medicare Y N If yes, ID#:_____

Insurance Y N If yes, ID#:_____

Name of Primary Insurance Company: _____

Policy ID#:_____

Policy Group#:_____

Employer Name: _____

Policy Holder Name: _____

Policy Holder SSN: _____

Relationship to Client: _____ Sex: M F DOB: _____

Insurance Company Address: _____
_____
_____

Insurance Company Telephone: _____

Insurance Authorization Number: _____

If not on the insurance panel for this client's carrier, are there out of network benefits: _____

Insurance Copay _____Insurance %: _____ Client%: _____

Insurance Deductible: _____ Deductible Met: _____

Insurance Reimbursement Rate: _____ # of Approved Sessions: _____

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Preferred Means of Contact

Please check below at least **two preferred** means of communication for receiving information (i.e., appointment confirmation, emergency cancellation, etc.). Information sent by email is not secured and confidentiality cannot be guaranteed.

_____ Telephone – include number: _____

Is it okay to leave a voicemail: ☐Yes ☐No

_____ Email – list email address: _____

_____

_____ US Mail – list address: _____

_____

_____ Other (including fax): _____

_____
Signature of client or legal guardian

_____
Date

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Cancellation/No Show Policy

A cancelled appointment delays our therapeutic work. When you must cancel, please give me at least 24 hours' notice. I am rarely able to fill a cancelled session unless I know at least 24 hours in advance. If you are unable to provide at least 24 hours' notice when you cancel, you will be charged the full fee for your session. A credit card number needs to be provided when initiating services at The Center of Collaborative Counseling & Psychiatry. Please note that insurance companies do not typically reimburse for missed appointments.

_____

Client Signature & Date

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

The Center for Collaborative Counseling & Psychiatry is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of Use of Your Health Information for Accounting Purposes:

We use an online accounting program and information about you, including a diagnosis code, will be entered into that program using the internet. In addition, statements may be emailed to you.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request to our office -- we are not required to grant the request, but we will comply with any request granted;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the health information kept by or for the office;
  - Is not part of the information that you would be permitted to inspect and copy; or,
  - Is accurate and complete.

  If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;

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- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

If you want to exercise any of the above rights, please contact Julie Kochevar, 2250 Point Blvd. Suite 140, Elgin, Illinois 60123, in person or in writing, during regular, business hours. She will inform you of the steps that need to be taken to exercise your rights.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Julie Kochevar at (847) 214-3651**.**

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Julie Kochevar. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services, whose street address and e-mail address is: Office for Civil Rights - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201.

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- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Abuse & Neglect

- We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law Enforcement

- We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

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Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, this Notice will be on the website.