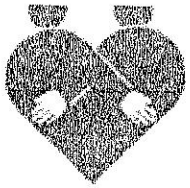

# Community Counseling Services & Associates, LTD

**PATIENT INFORMATION**

FIRST NAME_____ MI _____ LAST NAME_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SSN# _____ BIRTHDATE _____

HOME PHONE (___) _____ CELL PHONE (___) _____

WORK PHONE (___) _____ EMAIL _____

EMERGENCY CONTACT (Name/Phone Number/Relation)_____

**MAY WE LEAVE MESSAGES AT THE NUMBERS LISTED?_____

**PATIENT STATUS**

| GENDER: | MARITAL: | | |
|---|---|---|---|
| ___ MALE | ___ SINGLE | ___ SEPERATED | ___ EMPLOYED |
| ___ FEMALE | ___ MARRIED | ___ PARTNERSHIP | ___ FT STUDENT |
| | ___ DIVORCED | | ___ PT STUDENT |

PRIMARY CARE PHYSICIAN _____

PRIMARY CARE PHYSICIAN PHONE NUMBER (___) _____

NAME OF PSYCHIATRIST (IF ANY) _____

PSYCHIATRIST PHONE NUMBER (___) _____

IF PATIENT IS UNDER 18, WHO SHOULD BE BILLED? (Billable party must sign paperwork)

FIRST NAME_____ MI _____ LAST NAME_____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE (___) _____ CELL PHONE (___) _____

WORK PHONE (___) _____ EMAIL _____

INSURANCE/EAP INFORMATION

(Please give us your insurance card to copy. If you supply your insurance card you do not need to complete the next line.)

INSURANCE CO _____ ID # _____ GROUP # _____

INSUREDS: DATE OF BIRTH _____ Male/Female _____

EMPLOYER _____ SCHOOL _____

**BACKGROUND INFORMATION**

NAME _____ AGE _____ DATE _____

Marital Status: ____Single ____Married ____Separated ____Divorced ____Widowed ____ Partnership____ Living Together

LIST EVERYONE THAT LIVES WITH YOU AND FAMILY MEMBERS THAT DO NOT LIVE WITH YOU
(I.e. you're divorced and your son lives with his mother, then indicate your son)

| NAME | AGE | RELATIONSHIP | LIVES WITH YOU? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

1.) Please describe your reason for contacting us _____

2.) HOW HAS THIS PROBLEM AFFECTED YOUR: (Scale 1 to 5: 1 being it affects you a little, 5 being it seriously affects you)

| | DOES NOT APPLY | | | | | |
|---|---|---|---|---|---|---|
| Marriage/Partner | ____ | 1 | 2 | 3 | 4 | 5 |
| Family | ____ | 1 | 2 | 3 | 4 | 5 |
| Job/School Performance | ____ | 1 | 2 | 3 | 4 | 5 |
| Friendships | ____ | 1 | 2 | 3 | 4 | 5 |
| Financial Situation | ____ | 1 | 2 | 3 | 4 | 5 |
| Legal Situation | ____ | 1 | 2 | 3 | 4 | 5 |
| Health | ____ | 1 | 2 | 3 | 4 | 5 |
| Anxiety Level/Nerves | ____ | 1 | 2 | 3 | 4 | 5 |
| Mood | ____ | 1 | 2 | 3 | 4 | 5 |
| Eating Habits | ____ | 1 | 2 | 3 | 4 | 5 |
| Sleeping Habits | ____ | 1 | 2 | 3 | 4 | 5 |
| Ability to Concentrate | ____ | 1 | 2 | 3 | 4 | 5 |
| Control of your Temper | ____ | 1 | 2 | 3 | 4 | 5 |
| Child Rearing | ____ | 1 | 2 | 3 | 4 | 5 |

OVERALL: How serious is this problem for you? 1 2 3 4 5

3.) Why did you decide to seek help now?

4.) What therapy or treatments have you tried before?

Was it helpful?

5.) What would you like to accomplish by coming here?

6.) Please describe any medical problems. (Use back if needed)

List any medications you are taking _____

How long since your last physical _____

7.) **To be filled out by ADOLESCENTS (age 12 to 17)**

Have you ever used alcohol or drugs before? _____ Yes _____ No

Have you ever missed school because of alcohol or drugs? _____ Yes _____ No

Have you ever missed school to use alcohol or drugs? _____ Yes _____ No

Have you ever avoided non-users? _____ Yes _____ No

About how often do you get intoxicated or high? _____

Is there history of problems with alcohol/drug use in your family? _____ Yes _____ No

8.) **To be filled out by Adults (18 and over)**

Have you ever felt like you should decrease your alcohol or drug use? _____ Yes _____ No

Has a friend or relative expressed concerns about your use? _____ Yes _____ No

Have you ever felt guilty about your drinking or drug use? _____ Yes _____ No

Have you ever had to take a drink or drug the next day to steady your nerves? _____ Yes _____ No

Are you a recovering alcoholic or a recovering drug addict? _____ Yes _____ No

About how often do you get intoxicated or high? _____

Is there a history of problems with alcohol/drug use in your family? _____ Yes _____ No

# AUTHORIZATION AND RELEASE

I, _____ authorize the doctor/therapist to release any information including the diagnosis and records of any treatment or examination rendered to me/my child (circle one) during the period of such care to third party payers and/or the primary care physician I listed on page one of this intake. The information will be released only if it is being released for the purpose of evaluation, treatment, or payment collection.

I authorize and request my insurance company to pay directly to the doctor/therapist insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered n my behalf of my dependents within the agreed limit.

This authorization and release is valid for six months after services are terminated and the final balance is paid in full, unless otherwise specified.

X_____ _____
Signature of patient Date

X_____ _____
Signature of parent/guardian Date

# NOTICE OF PRIVACY PRACTICES

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORAMTION

## PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly **confidential**. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and client service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations
- If we are required by law to treat you; or
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
-

Any other uses and disclosers will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which can exercise by presenting a written request to the Privacy Officer:

- The right to restrictions on certain uses and disclosers of protected health information, including those related to disclosures to family members, or other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requests restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

# PATIENT ACKNOWLEDGEMENT OF RECIEPT OF THE NOTICE OF PRIVACY PRACTICES

525 E. North Street
Suite B
Bradley, IL 60915
(815) 933-0667

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing this document, I acknowledge that you have provided me with a copy of your Notice of Privacy Practices. The Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my respect or to agree to my requested restrictions, but if you do not agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Please Initial One

| | |
|---|---|
| Recurring Authorization: | |
| | |
| Cancel Authorization: | |

THE **ARDENT** COUNSELING CENTER
counseling for individuals of all ages

# Credit Card/ACH Payment Authorization Form

| | | |
|---|---|---|
| Name of Person authorizing payment: | | |
| Name of business (if Applicable and hereafter "Accountholder") | | |
| Address: | | |
| City | State: | Zip: |

| Credit Card type (please check one) | MC | ◯ | VISA | ◯ | Discover | ◯ | AMEX | ◯ |
|---|---|---|---|---|---|---|---|---|
| Credit Card Number: MasterCard or Visa or Discover | | | | | | | | |
| Expiration Date (MM/YY) | / | | | VID CODE (3-digit on Back) | | | | |
| Credit Card Number: (American Express): | | | | | | | | |
| Expiration Date (MM/YY) | / | | | VID CODE (4-digit on Front) | | | | |

| | | | | |
|---|---|---|---|---|
| Checking (Check one) | | Savings (Check one) | | Please Attach a Voided Check |
| Routing Number: | | | Bank Transit/ABA No. | |
| Financial Institution Name | | | City ,State, Zip Code | |

By completing and executing this form, the cardholder acknowledges and agrees that Rodasi LLC. dba "The Ardent Counseling Center" (hereafter "Company) is authorized as of the authorization date set forth below and subject to the terms and conditions set forth below, to charge the credit card, debit card, chard card, electronic check draft (ACH) or other payment card (each referred to herein as "Credit Card" or Check), specified above for the amounts billed to the accountholder or the card holder specified above for service rendered.

Company will sent the accountholder or cardholder an invoice for service rendered. Company will charge the above credit card or ACH for the amount specified in the invoice on or around the date of the invoice. The account holder/credit card holder should ensure such charge will not cause the credit card account or ACH draft to exceed any established credit /bank limits or available balances as on the date of charge/draft/ There will be a $25.00 penalty for any rejected charge pursuant to this authorization. Cardholder acknowledges that they will continue to be liable for any such rejected or any unpaid charges including all penalties. Cardholder further authorizes Company to initiate a chard or credit as necessary to correct any prior overpayment or underpayment of any invoice or any other charge or credit effected under this or prior authorization (s) Company and cardholder further acknowledge that if this payment authorization is for a recurring charge/ draft, then Company will inform cardholder of any variances in the recurring amount. Each charge will appear as a payment on the next invoice sent to accountholder/cardholder after the charge date. All charges and ACH debits will appear as Rodasi LLC and or The Ardent Counseling Center.

To Update/Cancel the above credit card information, please execute this form and check "Update information" or "Cancel authorization and fax back to number provided below. This authorization shall remain in effect until Rodasi LLC, dba The Ardent Counseling Center, receives a new form requesting an update or cancellation, and the Ardent Counseling Center has had sufficient time to clear any arrears and act on the authorization. Cardholder will continue to be liable for any invoices due and pending as of such termination. Cardholder is responsible for informing Company of and changes in the above information.

If you have any question on billing or credit card/ACH charges please contact our correspondence address, The Ardent Counseling Center 684 Barrington rd. Suite 112 Streamwood, IL 60107

| |
|---|
| Signature of Cardholder/Accountholder: |
| Authorization Date: |

**Community Counseling Services and Associates**
*525 East North St, Suite B*
*Bradley, Illinois 60915*
*Phone: (815)933-0667*

For internal use only:

Check one:
___ Enter in chart only
___ Send Records
___ Obtain Records

## AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

| Client Name: | | Date of Birth: | |
|---|---|---|---|

I hereby authorize the Community Counseling Services and Associates (CCSA) to release and/or obtain the information concerning the above named client with:

| Name of Person or Agency: | | | |
|---|---|---|---|
| Complete Mailing Address: | | Phone Number: | |

The information being released and/or requested will be used for the following purpose(s):

| | | |
|---|---|---|
| ☐ Ongoing evaluation and treatment | Referral | Litigation |
| ☐ Coordination of services and supports | Academic planning and placement | Insurance |
| ☐ Coordination of medical treatment | Personal file | Other: _____ |

| **INFORMATION TO BE RELEASED** | **INFORMATION TO BE OBTAINED**<br>*For dates of service from: to:* |
|---|---|
| ☐ Evaluation/Assessment | ☐ Social & Family History |
| ☐ Social History | ☐ Health & Treatment History |
| ☐ Diagnosis | ☐ Evaluation Results |
| ☐ Treatment or Service Plan | ☐ Records of Contact |
| ☐ Progress/Prognosis | ☐ Discharge Summary |
| ☐ Copy of Record | ☐ Medication List |
| ☐ Medication List | ☐ Prognoses/ Treatment |
| ☐ Discharge Summary | ☐ Legal Status/Legal History |
| ☐ Laboratory results (specify type & date: _____) | ☐ Grades, Test Scores, Conduct, Attendance |
| ☐ Billing Information | ☐ Educational/Vocational Plans |
| ☐ Other: _____ | ☐ Other: _____ |

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify Date of expiration): _____

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the CCSA. I understand that the person or agency receiving this information, in CCSA compliance with state regulations, will be notified not to disclose this information without further written consent. However, I understand that Community Counseling Services and Associates cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a client in a federally assisted alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosures of such information unless further disclosures are expressly permitted by written consent of the client or as otherwise permitted under federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2). I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting the CCSA at the above address. I understand that CCSA may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of research related treatment or creating information for disclosure to a third party, refusal to sign may result in denial of those services.

| **SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW** | **Type of Information** | **Authorizing** |
|---|---|---|
| I authorize the release of the information at the right, which requires specific consent: | Substance Abuse | Yes No |
| Signature of Client/Legal Representative | Mental Health | Yes No |
| Signature of Minor, if required: | HIV-related info | Yes No |

**Signature of Client/Legal Representative** _____ **Date:** _____

Relationship, if NOT the client: _____

**Witness Signature** _____ **Date:** _____

**To the recipient of mental health information:** Disclosure of mental health information may only be made pursuant to the written authorization of the individual or their legal representative, or as otherwise provided in Iowa Code 228. The unauthorized release of mental health information is unlawful, and civil damages and criminal penalties may be applicable to the unauthorized disclosure of mental health information.

☒ Copy given to client Initials: _____

# Community Counseling Services & Associates, LTD

## ATTENDANCE POLICY

1)Missing two appointments in a row will lead to removing recurring appointments. For example, if you are scheduled to come every Monday at 8, missing two appointments in a row will remove that standing appointment. You will have to call to schedule your next appointment so that we can discuss barriers to attendance.
2) Four missed appointments in a row, or 60 days of no appointments, can lead to case closure.
3) If you need accommodations (different appointment days or times) or are experiencing stressors that make it difficult to attend appointments, it is your responsibility to call me to let me know. I can only help you to make it easier to attend sessions if I know what is happening.
4) Not showing for an appointment, or **cancelling with less than 6 hours notice will result in a $75 cancellation fee.** Insurance companies do not pay for no-show or cancelled appointments. **You are responsible for paying this fee at the next session.**
5) If your case is closed, you are welcome to return for services at any time. You are also welcome to contact me for additional/alternative resources.
6) To cancel appointments, you can call the main line at 815-933-0667.

I understand the attendance policy and agree to follow these guidelines. I understand that if I do not follow this policy, I may be closed from services.

_____ _____
Print Client Name Date

_____ _____
Client Signature Date

_____ _____
Therapist Signature Date
525 E North Street Suite B
Bradley, IL 60915
815-933-0667

## FEES

**1) Payments for copays and self-pay services are required at the time of services are rendered.** With each visit unpaid, the balance becomes higher and more difficult to pay. You are investing in your wellness and payment for services is part of this investment in your recovery.
2) If there is a balance on your account, it is your responsibility to pay it at the next session or to sign a payment plan agreement to make reasonable contributions towards the balance at each visit. Financial stress will need to be documented and discussed in order to sign a payment plan for paying off account balances.
3) **If your balance reaches $300, you will not be able to come back until it is paid in full.**
**4) It is your responsibility to verify with your insurance company how much they cover for outpatient therapy with an LCPC.** While we call to verify your insurance

coverage, you are also obligated to call to verify costs you will be responsible for. **You will be responsible for payments not covered by your insurance company,** so please check what these costs are prior to your first visit so there are no surprises. CCSA does our best to also identify these costs prior to your first visit, but sometimes it is not possible for a variety of reasons.
5) Delinquent accounts may be turned over for collections after 60 days at the responsible party's expense.

I understand and accept the above stated terms of attendance and payment of fees. Any change in my financial or insurance situation, I will discuss with my therapist. I have read, understand, and agree to the above policies. I understand the fees of the services I engage in, and my responsibility and costs in covering those fees. I have discussed these policies with my therapist, if desired, and all questions have been answered to my satisfaction. I have been offered a copy of these policies. I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I understand that in the even of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that co-pays and deductibles are not negotiable.

## FEE SCHEDULE

| | |
|---|---|
| Standard Fees (Insurance covered) | |
| Intake Interview/Assessment | Varies by insurance |
| Individual Counseling Session (50 minutes) | Varies by insurance |
| | |
| Self Payments | |
| Intake Interview/Assessment | $110 |
| Individual Counseling Session (50 minutes) | $90 |
| Family/Couple's Counseling | $20 more per person attending |
| | |
| Additional Fees | |
| Cancelling with less than 6 hours notice | $75 |
| Phone calls over 5 minutes in length | $25 (for each 15 minutes) |
| Depositions, subpoenas, legal and/or court proceedings (initial cost due prior to court) | $300 |

I acknowledge and understand the fee schedule detailed above. **I understand that my insurance may not pay standard fees in full. I understand it is my responsibility to cover fees not reimbursed by insurance.**

**I understand that the ADDITIONAL fees listed above are NOT billed to any insurance companies and I am responsible for entirely.**

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

525 E North Street Suite B
Bradley, IL 60915