***Soulbrite Clinical Associates***
1550 Spring Rd. Suite 225
Oak Brook, IL 60523

Phone: 630-403-8735
Web: soulbrite.org

## CLIENT INFORMATION

Client Name:_____

Address:_____

Phone: _____ Email: _____

Is it ok to leave a voicemail? ___Yes ___No Is it ok to send an email? ___Yes ___No

Date of Birth: _____ Social Security Number: _____

Gender: __Male __Female

Which ethnic or racial group do you identify with the most? _____

Marital Status: ___Single ___Engaged ___Married ___Divorced ___Widowed

Occupation: _____ Highest Education Level:_____

If you have children, what are their ages? _____

What is your religious affiliation, if any?_____

## Emergency Contact

Name: _____ Relationship_____

Phone Number: _____ Alternate Number: _____

## Referral Information

How did you hear about us? ___Friend ___Family ___Professional ___Web ___Insurance ___Other

Referred by: _____

## If you are filing insurance, please complete below

Relationship to Insured: ___Self. ___Spouse. ___Child (Please complete below if other than self)

Insured's Name:_____

Insured's Address:_____

Insured's Date of Birth: _____SSN:_____

Insurance Company Name:_____

Member ID#: _____ Policy/Group#: _____

## Primary Care Physician Info

PCP Name:_____

PCP Address:_____

*Illinois law requires your therapist to notify your Primary Care Physician (PCP), if you have one, that you are seeking or receiving mental health services. We believe that it is desirable for us to confer and work together with your PCP on your care. Please indicate your desire by checking the appropriate box below:*

___ **I agree** for you to notify my PCP that I am seeing or receiving mental health services.

___ **I waive** notification to my PCP that I am seeking or receiving mental health services, and I direct you not to notify him/her.

___ I do not have a PCP and do not wish to confer with one. **I therefore waive** notification to my PCP that I am seeking or receiving mental health services.

## Mental Health History (please fill out as much as you feel comfortable)

Have you been in therapy before? ___Yes ___No

Have you been hospitalized for mental health reasons before? ___Yes ___No

Has anyone in your family of origin had counseling? ___Yes ___No

Is there any history of drug/alcohol abuse in your family? ___Yes ___No

If you answered YES to any of the above, please elaborate here:

_____

_____

_____

Are you taking any prescription medications at this time? ___Yes ___No

If yes, please list them and indicate what they were prescribed for:_____

_____

_____

Are you taking any supplements at this time? ___Yes ___No

If yes, which ones?_____

Do you have any medical conditions that we should know about? _____

_____

What is your daily or weekly alcohol intake?_____

What is your reason for contacting Soulbrite Clinical Associates? What are some goals for therapy?

_____

_____

_____

_____

## Intake Information

**Before treatment, you should be aware of the possible benefits and risks of counseling services.** The majority of individuals, couples, and families who obtain behavioral health services benefit from the process. The therapeutic process is generally quite useful and can result in improved mood, increased self-esteem, and greater ability to make choices that facilitate physical, emotional, and relational health, but some risks do exist. In the course of the therapeutic process individuals may experience unwanted feelings. If feelings of unhappiness, anger, guilt, frustration, or deep pain arise in counseling, the experience can be unexpected and distressing. In addition, individuals, couples, and families may find that the counseling process takes them to a place of making important life decisions. While your therapist will honor and respect your right to make decisions for yourself, important people in your life may not agree with a direction you decide to pursue. These experiences are likely to produce new opportunities as well as unique challenges. Don't hesitate to discuss treatment goals or procedures, especially if you experience unexpected discomfort or are concerned about an outcome of treatment.

**Counseling Process:**
At Soulbrite Clinical Associates, we will diligently work to provide the best therapeutic methods and tools available to you. For counseling to be successful, your commitment to the process is absolutely essential. This includes regular attendance and active participation as well as completion of the process through planned termination of counseling services. You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. Because all therapists want to see you have the greatest growth possible during the time you are here, we will work with you to plan a successful wrap-up. This is an important part of the counseling process, and we highly encourage you to honor your own effort by not neglecting this phase.

**Confidentiality:**
Legal and ethical standards require us to maintain confidentiality. Information cannot be divulged to any outside parties without your written consent with the following exceptions: if you are or become a danger to yourself or others, we become aware of any real or alleged abuse to children, elderly, or incapacitated people (in which case we are mandated reporters to the State of Illinois), and if we receive a properly issued subpoena accompanied by a court order to produce records. If your therapist receives clinical supervision, s/he will inform you of that process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

**Payment and Fees:**
Payment is expected at the time services are rendered. This office accepts cash, checks, debit cards, and credit cards. If payment is not made at the time of service, we ask you to settle the bill prior to the next session. You are responsible for the fees charged. In those cases where the client is a minor child, the parent/guardian is responsible for the bill. **If you need to cancel or change an appointment, notify the office at least 24 hours prior to the therapy appointment or group session in order to avoid a charge for the missed appointment or late cancellation. Please note that insurance companies will not cover missed or no-show appointments. You will be fully responsible for this charge if you do not give the proper 24-hour notification.**

**Insurance Fees and Diagnosis:**
We bill most insurance companies as a courtesy to you. You should be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis. This information will become part of the insurance company files, and in all probability some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, our office has no control over its use. It is important to remember that you always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage. It is in your best interest to verify the details of your health insurance policy and share that information with your therapist. <u>You remain personally responsible for deductibles, co-payments, co-insurance, non-covered, ineligible, or unauthorized services.</u>

# Privacy Notice

At Soulbrite Clinical Associates, we are committed to treating and using protected health information responsibly. This Notice describes the procedures we use to protect your information, and the circumstances under which your personal health information may be disclosed. It also describes your rights as they relate to this information. The rules for confidentiality of mental health records are recorded in the Illinois Mental Health and Developmental Disabilities Confidentiality Act and in the privacy rules of the Health Insurance Portability and Accountability Act. We strongly suggest you review these provisions in order to fully understand our procedures and your rights.

**We strive to protect your personal health information.**
At Soulbrite Clinical Associates, every effort is made to keep your personal health information private. Your records are kept in locked filing cabinets; computer data is password protected and every effort is made to prevent others from viewing your personal health information. If you have any concerns about your privacy, please bring them to our attention.

**You are entitled to copy or review your mental health records.**
You have the right to inspect and/or copy your health record. Emails that include clinical information may be included as part of the record. If, after reviewing your record, you believe that any statement is in error, you have a right to request that the person who made the entry make a correction. Anytime you request a revision, your request and the action taken must be noted in the record. If a professional chooses to stand by a statement with which you disagree, you have the right to add a written amendment stating why you believe the entry is in error. Any time that section of the record is released, your amendment must be included.

**The following individuals can access a mental health record without written authorization.**
1) an adult recipient of services; 2) the parent or guardian of a child who is under 12 years of age; 3) the recipient if he is 12 years of age or older; 4) the parent or guardian of a recipient who is at least 12 but under 18, if the recipient does not object or if the therapist does not find that there is a compelling reason for denying access, but nothing in this statement is intended to prevent a parent or guardian of a child who is at least 12 but under18 from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed; 5) a legal guardian of a recipient who is 18 or over; 6) an attorney, guardian ad litem, or power of attorney or other person who is legally authorized to access the records. We are happy to provide you with assistance in understanding the record.

**In the following circumstances, we may release your records without your permission.**
There are circumstances that impose limitations on a client's right or ability to maintain privileged communication. A therapist may disclose a record without consent: 1) to a supervisor, consulting therapist, or member of the staff team participating in the provision of services, a record custodian, or a person acting under the supervision of the therapist; 2) when a therapist believes a clear and immediate danger exists to one or more persons; 3) when disclosure is necessary to provide a recipient with emergency medical care or access to needed benefits when the recipient is not in a condition to waive or assert his or her rights; 4) when abuse or neglect of a child is suspected; 5) when a therapist is consulting with an employer, attorney, professional liability company, or other relevant business associate concerning the care or treatment he or she has provided, including disclosure to business associates who may help us pursue payment (but each of these recipients shall be held to HIPAA privacy standards and may not redisclose the information); 6) when a recipient introduces his or her mental condition or any aspect of services received for such condition as an element of a claim or defense; and, 7) in certain other legal situations where the court has decided that disclosure is directly relevant to the issue being investigated. Furthermore, as part of the Illinois Firearm Concealed and Carry Act (PA98-063), clinicians are required to notify the Illinois Department of Human Services of anyone who is determined to be a "clear and present danger" to themselves or others or determined to be developmentally or intellectually disabled.

**Additional rights.**
You have the right to request restrictions on certain uses and disclosure of personal health information. However, Soulbrite Clinical Associates is not required to agree to a requested restriction, and in some situations, is prohibited by law from agreeing to a requested restriction. You have the right to request and receive an accounting of disclosures that we make to other individuals.Soulbrite Clinical Associates reserves the right to change the terms of its Privacy Policy and to make the new Policy provisions effective for all personal health information that it maintains. You will be notified of any changes to the Policy.If you believe your privacy has been violated, first bring the matter to your therapist. If you have a dispute that cannot be resolved, please contact the Privacy Officer, David Hendricks, LCPC. You may also file a complaint with the Office for Civil Rights, U.S. Dept of Health & Human Services, 200 Independence Ave; S.W., Room 509F, HHH Building, Washington, DC 20201. There can be no retaliation for filing a complaint.

## Informed Consent to Treatment

I consent to take part in the treatment at Soulbrite Clinical Associates. I have received and read the I**ntake Information form** explaining the risks and benefits of treatment, the fees for services, and other policies, and agree to its terms.

I have received and read the **Privacy Notice** as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the Intake Information or Privacy Notice that I do not understand.

I understand that **I am responsible for my bill**. While Soulbrite Clinical Associates will assist me in pursuing insurance reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency. I understand that Soulbrite Clinical Associates may elect to end treatment if timely payment for services is not made.

I understand that I will be charged a full session fee for failing to show or for failing to give at least **24-hour notice when canceling an appointment**. I understand that insurance companies cannot be billed for this fee and therefore this fee will be my responsibility.

If I am electing to use my insurance benefits, I authorize release of the necessary information to my insurance company so that Soulbrite Clinical Associates, acting as my agent, may pursue payment for the services provided to me. I authorize insurance payments to be sent directly to Soulbrite Clinical Associates.

_____ _____

Client Signature *(Age 12 and older)* Date

_____ _____

Parent/Guardian Signature *(For clients younger than age 18)* Date

_____ _____

Other Family Member *(if attending therapy)* Date

# Credit Card Authorization

I understand that it is office policy that payments are required at the time of service or charge accrual. I voluntarily authorize Soulbrite Clinical Associates to charge my credit/debit card for any and all balances that I accrue. This includes the cost of sessions, phone consultations, and no show/cancellation fees.

We require your credit card information to be stored for future payment for some of the following reasons:

-Deductible has not been met for the current calendar year.
-Co-insurance may be applied to the charges.
-Service may be deemed as not a payable benefit for your plan.
-Policy has terminated, or there is a gap in coverage.
-You may wish to set up a payment for a large balance on account.

**By signing below, I authorize Soulbrite Clinical Associates to keep a credit cad on file for future payments and to charge all balances accord on the patient listed below with the information saved.**
I am aware that if any of my personal information has changed, I am responsible to notify Soulbrite Clinical Associates of the changes to ensure they have the most current information to contact me or process payment accurately.

Card Type (circle one): VISA MasterCard AmEx Discover Flex/HSA

Client name: _____

Card number: _____ Expiration Date: _____

Name on card: _____ CVV Security Code: _____

Signature of the cardholder: _____