Dear New Client,

Welcome to Family Service of Lake County, and thank you for choosing us to work with you and/or your family. Before your appointment, we ask that you complete the following paperwork and review the information provided, and then turn it in to front desk personnel or your therapist:

- Please complete the "Client Information and History Forms."
- If you are using insurance, please complete the "Insurance Verification Form." Please bring your insurance card(s) to your appointment; a copy will be retained for our records.
- If we are providing counseling for your child under the age of 12, please completethe "Child Pick-Up Authorization Form and Supervision Policy."
- Please read the following documents, and discuss with the Client Services Assistant if you have any questions:
  - "Financial Policies and Expectations"
  - "Credit Card Authorization Form"
  - "Informed Consent for Treatment"
  - "Client Consent/Waiver for Primary Care Physician Notification of Service Provision"
  - "Notice of Privacy Practices"

Thank you for choosing Family Service of Lake County to address your counseling needs. We look forward to serving you.

Nancy Sawle-Knobloch
Interim Executive Director

Debbie Hege, LCSW
Director of Counseling

MAIN OFFICE
www.famservice.org
777 Central Avenue, Highland Park, Illinois 60035
847-432-4981 847-432-7331 FAX

Family Service of Lake County
777 Central Ave, Suite 17
Highland Park, IL 60035
847-432-4981

CLIENT INFORMATION

Client Information

Name _____ / / ❑M ❑F ❑O Number of Persons in Family: __
First Middle Initial Last DOB Gender

_____
Street Apt # City State Zip

( ) _____ ( ) _____ ( ) _____
Home Work Ext Cell

Township:_____

Best Time to Call: _____ Best # to Call: ❑Home ❑Work ❑Cell Is it Ok to leave a Message? ❑Yes ❑No

Other Call Back Instructions: _____

Relationship Status

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partner ❑ Other_____

Employment Status

❑ Full Time Employment ❑ Part Time Employment ❑ Not Working ❑ Other_____

Student Status

❑ Full Time Student ❑ Part Time Student ❑ Not Student ❑Other_____

Responsible Party, if Different than Client:

Name _____
First Middle Initial Last

_____
Street Apt # City State Zip

( ) _____ ( ) _____ ( ) _____
Home Work Ext Cell

Best Time to Call: _____ Best # to Call: ❑Home ❑Work ❑Cell Is it Ok to leave a Message? ❑Yes ❑No

Other Call Back Instructions: _____

Emergency Contact

Name _____
First Last Relationship

( ) _____ ( ) _____ ( ) _____
Home Work Ext Cell

Demographic Information

Family Service of Lake County is supported by grants from local townships, foundations and corporations, as well as by the generosity of many private donors. By giving FSLC the following information; you are helping us provide accurate, general data about those we serve. All information is used for statistical and development purposes only. Your name is not attached to information given below. You are not required or obligated to provide this information, nor are services conditional on your providing this information. Thanks in advance for your help.

Ethnic Background

❑ Caucasian ❑ African-American ❑ Asian ❑ Latino/Hispanic ❑ Native American/Alaskan
❑ Native Hawaiian/Pacific Islander ❑ Multicultural ❑ Other/Unknown

Guardian (if client is a minor)

❑ Grandparent ❑ Parent ❑ Legal Guardian ❑ Other

Income Level

❑ $0 to $9,999 ❑ $10,000 to $29,999 ❑ $30,000 to $53,999 ❑ $54,000 to $84,999 ❑ $85,000 & above ❑ Do not wish to state

Client's Signature Confirms Receipt of Notice of Privacy Practices:_____ **Date:**_____

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HISTORY (page 1)

Reason for seeking counseling services at Family Service of Lake County?

_____

_____

_____

Have you ever seen a psychiatrist or psychotherapist before? _____ Yes _____ No

If yes, please list the name, when you were treated by this professional, and for how long:

_____

_____

If you are currently seeing a psychiatrist or psychotherapist, please list the name and phone number (will not be contacted without your consent):

_____

Please list all current medications below (include birth control pills, over the counter medication and herbal remedies – i.e.: decongestants, St. John's Wort, etc.).

Name of Medication	Dosage (mg)	How many times a day	On this for how long?	Side effects (if any)	Prescribing Physician

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HISTORY (page 2)

History of Non-Prescribed Substance Use						
Please provide the following information as it applies to you for the following substances:						
	Never Used	**Age first used**	**Date last used**	**Age at peak use**	**History of abuse**	**Current use/frequency**
Alcohol						
Cocaine						
Amphetamines / Speed / Adderall						
Cannabis						
Diet Pills						
Hallucinogens (LSD, mushrooms, Mescaline)						
Ecstasy						
Diuretics						
Tranquilizers						
Khat / Bath Salts						
Pain Pills (Vicodin, OxyContin, Dilaudid, Percocet, etc.)						
Laxatives						
Tobacco or “vape”						
Adderall						
PCP or Angel Dust						
Spice / K2						
IV Drug use						
Heroin						
GHB / Rohypnol						
Anabolic Steroids						
Caffeine (Coffee, Tea, Cola, Iced tea, Energy Drinks)						
Inhalants						
Benzodiazepines (Xanax, valium, Ativan, Restoril, Librium)						

What do you hope to accomplish in therapy?

_____

_____

_____

How long do you expect it to take to reach your goal(s)?

_____

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INSURANCE VERIFICATION

***if you are using insurance, please complete the following questions and give your insurance cards to staff to be copied**

Subscriber/Insured Information

Policy Holder's Name: _____

Policy Number: _____

Policy Holder's Relationship to Client: □**Self** □**Spouse** □**Child** □**Guardian** □**Other**____

Policy Holder's DOB _____/_____/_____ **Policy Holder's Gender M** □ **F** □ **O** □

_____
Street Apt # City State Zip

(_____)_____ (_____)_____ (_____)_____
Home Work Ext Cell

Primary Insurance

Primary Insurance Company's Name: _____

Insurance Company's Phone (____) _____ **Behavioral Health Phone (____)** _____

Policy #_____ **Employer** _____

Group #_____ **Plan Name** _____

Secondary Insurance

Secondary/Supplemental Insurance Company's Name: _____

Insurance Company's Phone (____) _____ **Behavioral Health Phone (____)** _____

Policy #_____ **Employer** _____

Group #_____ **Plan Name** _____

Managed Care Authorization

Are you part of a Managed Behavior Health Plan? □**Yes** □ **No If yes, Provider Name**:_____

Is precertification/authorization required? □ **Yes** □ **No If yes, by whom?** □ **Client** □ **Physician**

Phone number to pre-certify treatment: (____)_____

Have you received authorization for treatment? □ **Yes** □ **No If yes, please provide the following information if known:**

Authorization#_____ **#of Sessions Approved:** _____ **Start Date** ___/___/___

Patient or Authorized Person Signature

AUTHORIZATION TO FILE FOR AND ACCEPT ASSIGNMENT OF INSURANCE BENEFITS:
I authorize use and disclosure of my personal health information for the purposes of obtaining payment for my care. This includes the minimally necessary information for the filing of insurance claims. This authorization does not provide consent for release of my clinical records. Additional specific consent must be obtained for that purpose. I authorize direct payment/assignment of insurance and government benefits to Family Service of Lake County.

Client Signature:_____**Date:**_____

For Office Use Only

*Effective Date of Insurance:*_____

Type of Insurance:
□*PPO* □*HMO*
□*POS*
□_____

Family therapy (90834/90837) covered? □*Yes* □ *No*

*Deductible $*_____*How much met YTD $*_____ *Copayment/Coinsurance*_____

*Notes:*_____

*Therapist:*_____ Diagnosis Code**:**_____

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CHILD-PICK UP AUTHORIZATION FORM AND SUPERVISION POLICY

Child's name: _____ **DOB** _____/_____/_____ **Age** _____

Main pick-up person:

Name:_____H: (____)_____C: (____)_____

Relationship: □ Mother □ Father □ Step Mother/Father □ Grandparent □ Nanny/Caretaker □ Other___

Additional persons who may pick up child/children on a less frequent basis:

Name:_____H: (____)_____C: (____)_____

Relationship: □ Mother □ Father □ Step Mother/Father □ Grandparent □ Nanny/Caretaker □ Other___

Name:_____H: (____)_____C: (____)_____

Relationship: □ Mother □ Father □ Step Mother/Father □ Grandparent □ Nanny/Caretaker □ Other___

Name:_____H: (____)_____C: (____)_____

Relationship: □ Mother □ Father □ Step Mother/Father □ Grandparent □ Nanny/Caretaker □ Other___

Any person(s) NOT authorized to pick up my child/children:

Name(s) and relationship: _____

Child Supervision Policy:

- A parent, guardian or caretaker is expected to be responsible for minor children 12 years old and younger while in our building and offices and therefore should remain in the building during the session.
- Children should be escorted to our waiting room, not just dropped off in front of the building.
- Young children should not be left unattended at any time. Family Service of Lake County does not have staff to supervise unattended children. At the conclusion of your child's session, the therapist will escort him/her back to the waiting area to meet you.
- Please complete the top portion of this form, and then sign at the bottom of the page to identify adults who have your permission to pick up and drop off your child. Also **indicate any specific person(s) who *may not* pick up your child under any circumstances.** For your child's safety, therapists who are unfamiliar with a person picking up a child will ask that person to show identification confirmation that he/she has been authorized by parent to pick up child.
- If you have an older child (13 or older) and wish to leave the premises during his/her session, please make sure that you return prior to the scheduled conclusion of your child's session.
- Please clean up and remove any trash or disposable items such as diapers.
- Please pick up toys/books and return them to the storage bins.

_____ _____ _____

Print Parent/Guardian's Name **Parent/Guardian's Signature** **Date:**

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FINANCIAL POLICIES AND EXPECTATIONS

Our standard fee for services is $140 per session. Your financial information is held in strict confidence and won't be shared with anyone without your permission.

Clients Covered by Medical Insurance

If you have insurance that accepts FSLC and its providers, we will submit claims on your behalf. At your first session, we will ask for your written permission to file insurance on your behalf and to have benefits assigned to FSLC. Each insurance carrier determines which services are covered, how many sessions are allowed, and who are approved as providers of the service. We will work with you to maximize your coverage. You are expected to pay your copayments or your coinsurance percentage at the time of service. If we are in network, we will discount our standard charge based on the contracts we have with your insurance carrier. If we are out of network, we will discount our standard charge based on Usual, Customary and Reasonable (UCR) Charge Scale. If you have a deductible, this will be billed to you as it becomes known.

Self-Pay Clients

If you do not have insurance, you may pay for our services directly. If you are unable to pay the standard fee, you may be eligible for a subsidized fee based on your income and size of family. This can be discussed at the initial fee setting. Family Service of Lake County has limited funds from private donors and grants to help subsidize counseling for those who are unable to pay our full fee.

Expectations:

- Payment is expected at the time of service (copayments, percentage, self-pay)
- 24 hour notice is expected for sessions that are cancelled. You will be charged $70.00 (half the standard fee) if you do not give 24 hour notice. Insurance does not cover missed appointments. If your subsidized fee is less than $70, you will be billed that fee.
- It is expected that any balances on your account be paid upon receipt of your monthly statement.

Questions

Please direct any questions you have about these policies and expectations or specific questions about your account to our Business Office @ 847-432-4981 x 100.

Your Fee has been set at $_____ per session

I agree to pay the established fee: _____ **Date:** _____

Client or Responsible Party Signature

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CREDIT CARD AUTHORIZATION

Cardholder Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Credit Card Type: □ Visa □ MasterCard □ Discover

Credit Card Number: _____

Expiration Date: _____

Last 3 digits located on the back of the credit card: _____

□ I authorize Family Service of Lake County to charge my credit card $ _____ for each of my regular sessions.

□ I authorize Family Service of Lake County to charge my credit card one time for $ _____

□ I authorize Family Service of Lake County to charge $70, or my fee whichever is lower to my credit card for a missed appointment when I fail to give 24 hours' notice by voice mail to my therapist.

□ I authorize Family Service of Lake County to charge my credit card for any unpaid balance for which I am responsible that is 120 days past due, including co-payments.

You will be notified when any charge is applied to your credit card as a result of the above actions. If your card is charged in error, you will be reimbursed in full.
Please pay your balance due at the time of service to avoid use of this authorization.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signature: _____

Date: _____

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INFORMED CONSENT FOR TREATMENT

Welcome to Family Service of Lake County. Please take the time to read this document and talk with your therapist about any questions or concerns you may have regarding this Informed Consent.

The services being provided to you may include individual, couples and/or family counseling or psychotherapy. The term counseling and psychotherapy may be used interchangeably to describe a process involving psychological help which facilitates change. It addresses personal and/or family challenges and conflicts along with addressing mental health issues, such as depression, anxiety and bipolar disorder.

Psychotherapy has been shown to have many benefits. Therapy often leads to a better understanding of oneself, improved communication, acquiring healthy skills to help cope with life stressors and a better ability to solve problems affecting one's life. Your treatment will involve partnering with your therapist to develop a treatment plan which will address your specific presenting problem(s). Your treatment will often involve some type of work outside of the therapeutic hour, such as monitoring behaviors and/or thoughts, practicing skills learned in therapy or simply taking time to reflect on the therapy session. If you have concerns or questions about your therapy, you are encouraged to discuss them with your therapist. The relationship between therapist and client is critical to the success of therapy.

IN AN EMERGENCY

Family Service of Lake County is not an emergency facility. **If you have suicidal thoughts, thoughts about wanting to hurt yourself or someone else, or thoughts of committing dangerous acts, you should call 911 or go to your nearest Emergency Room and ask to speak to the mental health professional on call.** While our office is open Monday through Friday 9:00AM to 5:00PM, we cannot guarantee that if you leave a message for your therapist, you will receive a call back the same day. Listed below are additional numbers which are answered on a 24-hour basis and may be helpful to you if you feel the need to talk with someone:

Community Crisis Center—English (847) 697-2380

Community Crisis Center—Spanish (847) 697-9740

National Suicide Prevention Lifeline (800) 273-8255

CONFIDENTIALITY

Information disclosed to the therapist is kept confidential and not revealed to anyone outside Family Service of Lake County without your written permission. Staff may consult and collaborate on cases where therapeutically appropriate; each clinical staff member meets for supervision on a regular basis where information may be shared. All staff of Family Service of Lake County are bound to the same standards of confidentiality.

There are specific and limited exceptions to this confidentiality, which include the following:

A. If there is imminent danger to you or another person, the therapist is ethically bound to take protective actions. This may include contacting family members, seeking hospitalization for you, notifying any potential victim(s) or notifying proper authorities.
B. If the therapist has reason to believe that a child or vulnerable adult is being neglected or abused, the law requires that the situation be reported to the appropriate state agencies.
C. If a valid court order is issued for medical records, the therapist and the agency are bound by law to comply with such requests.
D. If you are under 18 years of age, the law may provide your parents the right to examine your treatment records. Before giving parents any information, we will discuss the record with you and if possible, will do our best to handle any objections you may have.
E. Files may be audited by funders, government agencies and internally reviewed for quality compliance.

This form is to be signed by all participating members in treatment. By signing, you are agreeing that you have read, understood, and agree to abide by its terms during our professional relationship.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist: _____ Date: _____

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CLIENT CONSENT/WAIVER FOR PRIMARY CARE PHYSICIAN NOTIFICATION OF SERVICE PROVISION

Pursuant to Illinois Law (PL 86-1434) you are hereby notified that it is desirable that you confer with your primary care physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, I am required to notify your primary care physician that you are seeking or receiving mental health services.

Please indicate your desire by checking the appropriate box:

( ) I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

( ) I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services, and I direct you NOT to notify him or her.

( ) I AGREE TO YOUR NOTIFYING my primary care physician that I am seeking or receiving mental health services.

My primary care physician is:

Name: _____

Address: _____

City: _____

Phone Number: _____

Please act in accordance with my instructions as indicate above:

Client printed name: _____

Client signature: _____ Date: _____

*Parent/Guardian signature: _____

(*required if minor)

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used or disclosed. It also describes your rights to access this information. Please review it carefully.

Family Service of Lake County is committed to protecting your privacy and the confidentiality of the information you share. We will only release information about you in accordance with Federal and Illinois law. If you have any questions about these policies or your rights, please feel free to talk with your therapist, Debbie Hege, Director of Counseling, or Carrie Callas, Executive Director at 847-432-4981.

Use and Disclosure of Protected Health Information

In order to effectively provide you with care, there are times when we will need to share your health information with others beyond Family Service of Lake County. These include:

For Treatment

We may use or disclose your health information to provide, coordinate, or manage your counseling, therapy and related services. For example, your health information may be shared with a physician or other health care providers who are also caring for you.

However, under Illinois law, except in emergency situations, we cannot release your health information without your consent. We will discuss situations where we would like to share your health information and request your written consent to do so. These consents specify the person or agency to whom information will be shared, the purpose or need for information, what information will be shared and time limitations. Your consent can be withdrawn at any time and you have the right to inspect and request a copy of any written in- formation to be released. Emergency situations include those where there is a risk to health or safety for clients or others.

For minors under the age of 12, the minor's parents, guardians, or agent under health care power of attorney, may authorize disclosure of information. Children over 12 and under 18 will be informed and asked if they object to disclosure of information. If they object, their protected health information will not be released.

In addition, the minor's therapist may find that there are compelling reasons for denying access to or release of information and may deny release. Compelling reasons include but are not restricted to the clinical best interest of the minor or legal custody conflict where independent evaluations can be sought elsewhere that would not compromise the therapy relationship with the minor.

For Payment

We may use or disclose your health information so that the treatments and services you receive may be billed and payment may be collected from you, an insurance company or a third party. As part of our intake process, we may ask your verbal permission to contact your insurance carrier to verify coverage and to obtain authorization for services. If insurance is involved, once you become a client of Family Service of Lake County, you will be asked to give us written authorization to submit claims on your behalf. In processing insurance claims for services, Family Service of Lake County is committed to providing only the minimum necessary information required. You have a right to restrict certain disclosures of your protected health information to your health plan, if you pay out of pocket in full for the services provided to you.

For Healthcare Operations

We may use or disclose your health information in connection with our health care operations including but not limited to the following:

- Quality assessment and improvement activities,
- Related functions that do not include therapy, e.g., scheduling appointments,
- Competence or qualification reviews of health care professions or
- Training, accreditation, certification, licensing or credentialing activities.

For Individuals Involved in Your Care or Payment for Your Care

With your written consent, we may disclose the minimum necessary information about you to your family or other persons you identify who are involved in your care or who help pay for your care.

In an emergency situation, we may exercise our professional judgment to determine whether communications about you is in your best interest, who is the appropriate person to contact and what health information is relevant to their involvement in your health care. If you have identified an emergency contact person, every effort will be made to contact that person first.

To Avert a Serious Threat to Health or Safety

As required by law, we may disclose health information about you when necessary to prevent a serious threat to your health or safety or the health and safety of others. Any disclosure of this kind, however, would be made only to someone able to help prevent the threat.

Other Communications with You

We may use and disclose your health information to contact you at the address and telephone numbers you give us about scheduled or canceled appointments, registration or insurance updates and billing and/or payment matters. Unless you tell us otherwise, we may leave messages about appointments or other reminders on your telephone or with a person who answers the phone.

As Required by Law

We may disclose your health information if court ordered. Your health information is not subject to subpoena without a court order.

Child or Vulnerable Adult Abuse or Neglect

We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or vulnerable adult abuse or neglect.

Health Oversight Activities and Specialized Government Functions

We may disclose information to governmental health oversight authorities or agencies for activities authorized by law, such as audits, investigations, or inspections of clinical records by Medicare or licensure boards. When services are funded by the government, we may disclose information for the coordination of your care.

Deceased Patients

We may disclose PHI regarding deceased patients as mandated by state law, or to a family member, or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies

We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Criminal Activity and Threats of Danger to Others—Present and Past

We may share information with law enforcement to apprehend a criminal, if a crime is currently occurring, is committed on our premises or against our staff. We also have the right to involve law enforcement when we believe an immediate danger exists to some identifiable person and may imminently occur. However, past criminal activities shared in therapy are protected by confidentiality and will not be disclosed without your written permission.

Fundraising

As a not-for-profit provider of health care services, we often need assistance in raising money to carry out our mission. However, we will not use your health information, e.g., name, address or telephone numbers, to solicit contributions. We will not sell protected client health information for any marketing reason. You will have the opportunity to opt out of receiving communications from FSLC that may include solicitations for contribution. This does not prevent you from becoming a friend of Family Service of Lake County independently.

Your Rights Regarding Your Health Information

You have the following rights under Illinois and Federal Law:

Right to Inspect and Copy

You have the right to inspect your Clinical Record, generated by Family Service of Lake County and its providers. However, we may request that this review be done with your therapist or the Director of Clinical Services. You may request a copy of your Clinical Record. You will be charged a reasonable fee for copying and postage. The original Clinical Record is the property of Family Service of Lake County and is never released.

Right to Release Clinical Record and Protected Health Information

You may consent in writing to release a copy of your Clinical Record and/or protected health information to others, e.g., another health care provider; your attorney or others who you wish to have knowledge of your care. Your consent is revocable at any time, but only applies to future disclosures and not to disclosures previously authorized. Except as described in this Notice or as required by Illinois and Federal law, we cannot release your protected health information without your written consent.

Right to Request Confidential Communication

You have the right to ask us to communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by sending materials to a P.O. Box instead of your home address or you may ask us to only call your cell phone. We will not ask the reason for your request and will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

Right to Amend Clinical Record

If you believe that something in your record is incorrect or incomplete, you may request that we amend it. To do this, contact the Director of Counseling or Executive Director. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. We are not obligated to make all requested amendments, but will give each request careful consideration. If your request is denied, you have a right to file a statement outlining your disagreements or objections with us. This statement will be attached to your Clinical Record.

Right to an Accounting of Disclosures or a Breach of Security

You have the right to ask us for an accounting of disclosures. This is a listing of those individuals or entities that have received your health information. The listing will not cover health information that was given to you or your personal representative or to others with your permission. It will not cover health information that was given in order to provide care for you, facilitate payment for you healthcare services and assist Family Service of Lake County in its operations. And it will not include information we are required to release by law or court order

To receive information regarding disclosure made for a specific time period (no longer than six years); please submit your request in writing to our Director of Counseling Services or Executive Director. We will notify you of the cost involved in preparing this list. Please note that Clinical Records are only kept for seven years after therapy is terminated for adults and for seven years after the majority (age 18) for minors. After that point they are destroyed.

You have a right to be notified if there is a breach of your unsecured protected health information. This would include information that could lead to identity theft. You will be notified if there is a breach or a violation of HIPPA Privacy Rule and there is an assessment that your protected information may be compromised.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer Debbie Hege, Director of Counseling at 777 Central Ave., Highland Park, IL 60035, or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 618-0257. **We will not retaliate against you for filing a complaint.**

Changes in Policy

Family Service of Lake County reserves the right to change its Notice of Privacy Practices based on the needs of the agency and changes in state and federal law.