NEW CLIENT INTAKE FORM

Client Information:

Full Name:_____Date:_____

Address:_____Date of Birth:_____

City/State/Zip:_____

Home Phone:_____Cell phone:_____

Work Phone:_____Email Address:_____

Which phone number would you prefer to receive voice mail messages on? _____

Social Security Number:_____Marital Status:_____

Employer or School Name:_____

Employer Address, City, State, Zip:_____

Employed: ( ) Full time ( ) Part time Student: ( ) Full time ( ) Part time

Occupation:_____Education:_____

Party Responsible for Payment: (if different from above please fill out entirely)

Name:_____Date of Birth:_____

Address:_____City/State/Zip:_____

Home Phone:_____Cell Phone:_____

Work Phone:_____Marital Status:_____

Social Security Number:_____

Employer or School Name:_____

Employer Address, City, State, Zip:_____

Insurance:

Name, birth date and social security number of insured:

_____

_____

Insurance Company:_____Telephone Number:_____

Group and other insurance ID numbers:_____

Medical Information:

Health Problems:_____

Physician Name and Phone Number:_____

Current Medications and Dosage:_____

Please read and sign the following agreement. Do not sign it unless it is clear to you.

I have reviewed the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices. I understand my and Mind Body Connection, LLC's rights and responsibilities, and agree to be bound by those documents. I understand that my therapist may, and give permission for my therapist to, discuss my case with other therapists at Mind Body Connections, LLC and within the Estuary Center community for supervisory purposes and collaborative treatment as indicated by my therapist's judgment. I give Mind Body Connections, LLC permission to bill my insurance company for services. I understand that I am responsible for paying my fee, regardless of whether my insurance covers it.

Signed:_____Date:_____

Witness:_____Date:_____

I authorize Mind Body Connections, LLC to charge my credit card (Visa, Discover or Master Card) for any balances overdue by 90 days.

_____ _____ _____

Signature Credit Card Number Exp. Date

Office Use Only below this line

Diagnosis Code: Session Fee:

Pre-certification and verification of benefits:

Deductible: % paid by insurance: Maximum fee:

Yearly Maximum: Lifetime maximum: Marital covered?

How to bill?

Billing address_____

If client has BCBS insurance: Date of current Illness/injury:_____

Same/Similar Illness-first date:_____

Billing Instructions:

☐File with insurance company ☐Request insurance company to reimburse client directly

☐Client will handle insurance if any ☐ Send monthly bill to client ☐ Do not bill client

PSYCHOTHERAPIST – CLIENT SERVICES AGREEMENT

Welcome to Mind Body Connections, LLC. We are glad you have chosen us as your place for personal growth and recovery. This document contains important information about our professional services and business practices. **Please read it carefully** and feel free to discuss any questions you have with your therapist.

Philosophy of Care at Mind Body Connections

We believe that treatment of the whole person is necessary for growth and development. This means that psychological, physical, spiritual, relational and fiscal issues may be addressed in therapy. Therapy may occur in a talk-therapy style and/or may include experiential components. Furthermore, therapy is most effective when the Client is active in the therapeutic process. This means you will be expected to work on things discussed in therapy both during session and at home.

Psychotherapy has both benefits and risks. Risks sometimes include painful feelings such as sadness, guilt, anxiety, anger, loneliness and helplessness. Therapy also often involves discussing unpleasant aspects of anxiety and distress as well as better relationships, greater self-esteem and resolution of specific problems. Unfortunately there are no guarantees of therapy outcomes.

The First Few Sessions

In the first few sessions your therapist will want to evaluate your treatment needs and learn more about you. During this time you and your therapist will work together to create treatment goals and an initial plan for treatment. Most importantly, this is your time to evaluate your comfort level and confidence in your choice of therapist. Your therapist will also be evaluating if they are a good choice of therapist for you and your specific needs and goals at this time. If for some reason you do not feel as though you are with the right therapist for you, please tell your therapist, as we would like to assist you in finding the right match.

Contacting Therapists and Emergencies

Calls are answered by a confidential voice mail system and each therapist has their own direct extension. Therapists check their voice mail each business day unless they are unavailable for an extended period of time. If your therapist is away, they are responsible for asking another therapist to be available to you, and their contact information will be included in your therapist's outgoing voicemail message. Therapists will make every effort to return calls within 48 hours. It is best to leave some times when you are available to be reached. If you need to reach your therapist more urgently you can call Stacey on her direct line at (312) 543-2133 or email her at staceyhurst67@gmail.com. You can reach Heather on her direct line at 708-257-3830 or email her at heatherrandazzo@gmail.com. **If your therapist is unavailable and you are experiencing an emergency please call the nearest hospital and ask for the psychiatrist on call or dial 911.**

Professional Records

The laws and standards of the mental health profession require therapists to keep Protected Health Information (PHI) about you in your clinical record. It is important to understand that pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and updated in 2013, your therapist may keep PHI about you in two sets of professional records. One set is your clinical chart, which may be accessed by third parties (such as insurance companies) with your written authorization. Some therapists keep a second record, referred to as Psychotherapy Notes. These notes are only for use by your therapist and may include contents of therapeutic conversations, analysis of those conversations and how they impact treatment. These notes are kept separate from your clinical record and cannot be released to insurance companies without your authorization. Insurance companies cannot penalize you if you refuse to authorize disclosure of psychotherapy notes. You may examine and/or receive a copy of your clinical and psychotherapy notes if you request this in writing. Because these records can be misinterpreted it is recommended that you review them in the presence of your therapist or have them

forwarded and reviewed with another mental health provider. Your therapist may charge a copying fee if you request of copy of these records.

Records of Minors

Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and the therapist finds no compelling reason to deny the access. Parents can request information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed. Since parental involvement, if usually crucial to successful treatment, it is recommended that Clients between 12 and 18 years of age and their parents enter into an agreement that allows parents access to treatment information.

For children under the age of 18, all paperwork should be co-signed by both parents. Signature of both parents is required in all cases of separation and all divorce situations involving any type of joint custody. Although not required by law, it is preferred to have both parents agree to treatment even in cases of sole custody with no stipulation regarding medical treatment.

Cost

The fee for a 60 minute session is $150. For individuals struggling to afford co-payments or cost of sessions please speak with your therapist about your situation since it is likely that we could work out an alternative financial arrangement. It is also important to know that fees may be charged for lengthy telephone conversations and time spent providing other services on your behalf. This may include extensive report writing, preparation and photocopying records or treatment summaries, consulting with other professionals with your consent, and attendance at staffing. If you become involved in legal proceedings that require your therapist's participation you will be expected to pay for all of their professional time including preparation and transportation costs, even if they are called to testify by another party. Please discuss this with your therapist so that you clearly understand what services you will be charged for. In addition, therapists reserve the right to limit phone calls or other uses of their time to what they consider clinically appropriate. They will discuss these limits with you should they become an issue.

Use of Insurance

Insurance is a complex issue. **We ask our Clients to call their insurance company to discover what mental health/chemical dependency coverage is available.** Mental health coverage is usually different than physical health coverage. Please ask your insurance company if you need pre-certification, what your co-pay is given our hourly rate, and how many sessions you are allowed in what period of time. We reserve the right to call your insurance company and verify coverage and benefits. We provide the courtesy of billing your primary insurance company and ask for you to make your co-payment at the time of service. We also ask that you assume the responsibility of tracking the usage of allotted sessions. In this regard you should take the initiative to discuss with your therapist (1) the number of sessions remaining before further approval is needed, and (2) when no further sessions are available under your policy.

Ultimately you are responsible for full payment of fees that your insurance company does not agree to cover. Therefore it is important to you to fully understand your coverage benefits regarding mental health and/or chemical dependency. You will be responsible for discussing with your health insurance company any disputes regarding coverage. If you are disputing a claim for lack of payment with your insurance company Mind Body Connections, LLC, may request that you pay your balance with us and agree to be reimbursed by the insurance company at a later date if the matter is eventually resolved.

Other Billing Issues

Mind Body Connections, LLC, has a 24-hour cancellation policy for all sessions including group therapy. Insurance companies do not cover missed appointments. You will be billed $60 if you fail to cancel with at least 24 hours notice.

We ask that you provide a credit card number for us to keep on file to cover balances that are more than 30-days overdue. We will notify you in the event that we bill your card.

Mind Body Connections, LLC, does use a collections agency and may do so if an account is 90-days past due and compliance with a suitable payment plan has not occurred. If it is necessary to take legal action to collect fees then attorney's fees and costs will be included in the claim. Rather than enter an adversarial situation we encourage you to speak directly to your therapist should financial issues arise which make timely reimbursement impossible.

Confidentiality

Illinois law protects the privacy of all communications between a Client and a mental health provider. In most situations, if you are 18 years of age or older, your therapist can only release information about your treatment to others if you sign a written authorization form and meet certain legal requirements imposed by HIPAA and/or Illinois law. However, there are several situations in which no authorization is required. Please see Mind Body Connections, LLC, Notice of Privacy Practices for further explanation and clarification.

Therapists are mandated reporters and as such we have the legal obligation of notifying appropriate authorities in the following situations. Please note that these situations are handled with the utmost care to protect those at risk for harm and with respect to the Client's confidentiality.

- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself.
- If you have made a specific threat of violence against another or if your therapist believes you present a clear, imminent risk of serious physical harm to another.
- If your therapist has reasonable cause to believe that a child under 18 known to your therapist in her professional capacity may be abused or neglected by a parent, caretaker, or other person responsible for the child's welfare.
- If your therapist has reason to believe that an adult over 59 years old, or under 60 years old and who is disabled, has been abused, neglected, or financially exploited in the preceding 12 months.
- In accordance with Illinois Firearm Concealed Carry Act of 2013 if you are determined to be a clear and present danger to yourself or others, developmentally disabled or intellectually disabled your therapist may be responsible for reporting your mental health information to the Illinois Department of Human Services.

Statement of Independence

Mind Body Connections, LLC is located at Estuary Center. Estuary Center is comprised of multiple independent practitioners who share certain expenses and administrative functions. That said, Mind Body Connections, LLC is independent from all other practitioners at Estuary Center, and is not responsible for the actions of the other professionals at Clarus Center. Although independent from those practitioners, we sometimes consult with them regarding our Clients' situations. By signing below you grant your therapist permission to consult with the other practitioners at Estuary Center.

_____ _____

Signature of Client (12 years and older) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Signature of Parent/Guardian (children up to 18 years) Date

_____ _____

Therapist Signature Date

PAYMENT CONSENT FORM

Client Name _____
Last First Middle

I agree to be responsible for full payment of my bill due to Mind Body Connections. I understand that Mind Body Connections prefers to receive payment in the form of check or cash. I also understand that Mind Body Connection may charge my credit card for any unpaid or overdue balances. I agree to provide a current, valid credit card for this purpose. I understand that charges may appear on my credit card statement as Professional Charges, Square, or Mind Body Connections, LLC. I authorize Mind Body Connections, LLC to charge my credit/debit card for professional services as follows:

Please Initial

_____ This visit only, for the amount of $ _____.

_____ All visits in the next 12 months, beginning _____/_____/_____ not to exceed $_____ total.

_____ Recurring charges, date(s) of service _____/_____/_____ to _____/_____/_____, not to exceed $_____.
_____monthly, _____semimonthly, _____weekly, _____per visit.

_____ **To charge my card for the balance of fees not paid by my insurance company within 90 days.**
(*required*)

Type of Card:
_____ Visa _____ MasterCard _____Discover _____Medical Flex/Savings

Name as it appears on Card _____

Card Holder's Address _____

Credit Card Number _____-_____-_____-_____, CVV Number _____
A 3-digit number on the back of credit card

Expiration Date _____

Card Holder Signature: Date:

AUTHORIZATION FORM

This form, when completed and signed by you, authorizes employees of Mind Body Connections, LLC to release and obtain protected information to/from the person(s) or agency or agencies you designate. I authorize Mind Body Connections, and administrative staff to release and/or obtain the following:

___verbal exchange ___clinical chart (excludes psychotherapy notes)
___billing records ___other

This information should only be released to or received from (names and addresses):

1._____ 3._____

2._____ 4._____

I am requesting Mind Body Connections, LLC to release and to obtain this information for the following reasons:

____At the request of the client ____For consistency of treatment
____For treatment planning and implementation ____For Payment Purposes

This authorization shall remain in effect until _____(usually one year from today's date). **If no calendar date is stated, information may be released only on the day the authorization form is received by Mind Body Connections, LLC.**

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to my therapist at Mind Body Connections, LLC. However, revocation will not be effective to the extent that my therapist has already released information based on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand I have the right to inspect the disclosed mental health information. I understand that Illinois Law prohibits re-disclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such a re-disclosure. I further understand that if information is released to a party in another state, re-disclosure of information may be allowable according to their state law. I also understand that once Mind Body Connections, LLC releases information, it has no responsibility or control over how that information is stored or utilized.

_____ _____
Signature of Client (12 years and older) Date

_____ _____
Signature of Parent/Guardian (children up to 18 years) Date

_____ _____
Signature of Parent/Guardian (children up to 18 years) Date

MIND BODY CONNECTIONS, L.L.C.
NOTICE OF PRIVACY PRACTICES
Version IV: 10/2014

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures of Protected Healthcare Information

a. Mind Body Connections, L.L.C. may use or disclose your Protected Health Information (PHI) for treatment, payment and healthcare operation purposes with you written authorization.

i. To help clarify these terms, here are some definitions:

1. "PHI" refers to information in your health record that could identify you.
2. "Treatment" is when your therapist provides, coordinates or manages your healthcare.
3. "Payment" is when Mind Body Connections, L.L.C. obtains reimbursement for services.
4. "Healthcare Operations" are activities that relate to the performance and operation of our practice.

b. Mind Body Connections, L.L.C. may use or disclose PHI for purposes outside of treatment, payment or healthcare operations, if we obtain your authorization prior to release of information.

i. You may revoke all such authorizations of PHI at any time provided each revocation is in writing. You may not revoke an authorization to the extent that:

1. Your therapist has acted on that authorization or
2. If the authorization was obtained as a condition of obtaining insurance coverage. The law provides the insurer the right to contest the claim under the policy.

II. Uses and Disclosures of PHI Without Your Authorization

a. Therapists may use or disclose PHI without your consent or authorization in the following circumstances:

i. **Consultation with other health and mental health professionals outside Clarus Center.** During such consultations your therapist cannot reveal any information that identifies you without your written consent. All other professionals are also legally bound to keep the information confidential. In most cases your therapist will not tell you about these consultations unless it is beneficial to your work together. All consultations will be noted in your clinical record.

ii. **Teaching and supervision.** At times you therapist may refer to clinical cases for teaching or supervision purposes. In these situations your therapist will not reveal any information that could identify you. In most cases your therapist will not discuss these occurrences with you unless it is beneficial to your treatment.

iii. **Within Estuary Center and Administrative.** At Estuary Center independent practitioners consult with each other regularly as a means of providing the highest quality of care to their clients. Mind Body Connections, L.L.C. also employs administrative staff. Your therapist may need to share protected information with these individuals for both clinical and administrative purposes such as scheduling, billing and quality assurance. All mental health professionals are bound by the same rules of confidentiality. All staff members

have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the oversight of a professional staff member.

iv. **If you are involved in a court proceeding.** Your therapist cannot disclose any protected information to the courts without a court order. If you are involved in or contemplating litigation, you should consult your attorney to determine whether a court would be likely to order your therapist to disclose information. In some cases, including but not limited to child custody proceedings and situations in which your emotional condition is an issue, a judge may require your therapist to testify in court. If it is your decision to open your protected information to the courts, please be advised that not only your clinical chart (PHI) may be opened but the Psychotherapy Notes that your therapist might keep in a separate file may be brought into the court, even if that is not what you wish. Unfortunately, once you offer your record for the court, you may not choose what is disclosed. It is advisable that you review records with your therapist and your attorney before making such a decision.

v. **Government.** If a government agency is requesting information for health oversight activities, your therapist may be required to provide it for them.

vi. **Malpractice Suits.** If you file a lawsuit against your therapist, they may disclose all of your record (including PHI and Psychotherapy Notes) regarding you to defend themselves.

vii. **Workman's Compensation.** If you file a worker's compensation claim and your therapist is rendering treatment or services in accordance with the provisions of Illinois Worker's Compensation law, your therapist must, upon appropriate request, provide a copy of your record to your employer or their designee.

III. **<u>Therapists are mandated reporters and as such have the legal obligation of notifying appropriate authorities in the following situations. Please note that these situations are handled with the utmost care to protect those at risk for harm and with respect to the clients broken confidentiality.</u>**

a. **If your therapist believes you present a clear, imminent risk of serious physical or mental injury or death to yourself,** they are required to take protective actions that can include notifying the police, seeking hospitalization or releasing relevant information to friends or family in order to keep you safe.

b. **If your therapist has reasonable cause to believe that a child under 18 known to them in their professional capacity may be abused or neglected by a parent, caretaker or other person responsible for the child's welfare,** the law requires that they file a report with the local office of the Department of Children and Family Services. Once a report is filed your therapist may be required to provide additional information.

c. **If your therapist has reason to believe that an adult over 59 years old, or under 60 years old and disabled, has been abused, neglected or financially exploited in the preceding 12 months,** the law requires them to file a report with the agency designed to receive such reports by the Department of Aging. Once such a report is filed your therapist may be required to provide additional information.

d. In accordance with **Illinois Firearm Concealed Carry Act of 2013** if you are determined to be a clear and present danger to yourself or others, developmentally disabled or intellectually disabled your therapist may be responsible for reporting your mental health information to the **Illinois Department of Human Services**.

IV. **<u>Patient Rights and Therapist Duties</u>**

a. Patient Rights

i. **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of PHI. However, we are not required to agree to a restriction you request.

ii. **Right to Receive Confidential Communication by Alternative Means and at Alternative Locations** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example,

you may request all written communication be sent to an address other than your home address.

iii. **Right to Inspect and Copy** – You have the right to inspect and obtain a copy or PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained. On your request, your therapist will discuss with you the details of the request for access process.

iv. **Right to Amend** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request may be denied. On your request your therapist will discuss with you the details of the amendment process.

v. **Right to an Accounting** – You generally have the right to receive an accounting of disclosures of PHI. On your request your therapist will discuss with you the details of the accounting process and when if applies.

vi. **Right to a Paper Copy of Notice of Privacy Practices** – You have the right to obtain a paper copy of this notice from Mind Body Connections, L.L.C. upon request.

b. Therapist Duties

i. Your therapist is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.

V. Statement of Independence

a. Mind Body Connections, LLC is located at the Estuary Center. Estuary Center is comprised of multiple independent practitioners who share certain expenses and administrative functions. That said, Mind Body Connections, LLC is independent from all other practitioners at Estuary Center, and is not responsible for the actions of the other professionals at Estuary Center. Although independent from those practitioners, we sometimes consult with them regarding our patients' situations.

VI. Questions and Complaints

a. If you have questions about this notice, disagreement wish a decision made about access to your records or other concerns about your privacy rights, please talk to your therapist.

b. If you believe that your privacy rights have been violated and with to file a complaint with Mind Body Connections, L.L.C., you may send your written complaint to Mind Body Connections, L.L.C. and to the Secretary of the U.S. Department of Health and Human Services.

VII. Effective Date, Restrictions and Changes to Privacy Policy

a. The terms of this notice are unchanged since our first version, and thus have been in effect since April 14, 2003. We reserve the right to change the privacy policies and practices described in this notice, and make those changes effective for all protected information that we maintain. You will be notified if such changes occur. We will post a new notice in the waiting area, post the revised notice on our website, and have paper copies available. If substantial changes are made to this agreement and you are no longer in treatment with us, you will receive notification via mail within 60 days of the revision. If we fail to attempt to contact you then we are required to abide by the terms currently in effect.

SIGNATURE PAGE

Please initial the following statements to indicate that you agree. If an item is not applicable please write N/A.

_____ 1) I have completed and signed the **New Client Intake Form**.

_____ 2) I have read and signed the **Psychotherapist-Client Services Agreement**.

_____ 3) I have completed and signed the **Payment Consent Form**.

_____ 4) I have completed and signed the **Authorization Form**.

_____ 1) I have received a copy of **Mind Body Connections Notice of Privacy Practices**.

_____ 4) I have provided my **insurance card** to be photocopied.

_____ 5) I have provided my **credit card number** for coverage of overdue balances.

_____ 7) I agree to hold confidential the identities and personal information of any other clients that I may see or interact with at Mind Body Connections and Clarus Center.

Your signature below indicates that you have received the Psychotherapist-Client Services Agreement and the Notice of Privacy Practices and that you agree to abide by its terms. These documents represent an agreement between you and your therapist. You may revoke this agreement in writing at any time. However, revoking either of these two agreements will result in termination of professional services provided to you by your therapist. Your signature below also indicates that you have initialed all the above statements which were applicable.

Client_____ Date_____

Parent/Guardian* _____ Date_____

Parent/Guardian*_____ Date_____

Witness_____ Date_____

*Parent signature is required for clients under age 18. Signature of both parents is usually required.