Partners in Pride® Wellness Center 630-299-9004
682 W. Boughton Road, Suite B, Bolingbrook, IL 60440

Intake Form for Minor

Client Information

Client Name (First and Last) | Optional: Nickname / Preferred Name

D/O/B Client | Optional: Pronouns

Address | City | State | Zip

Parent / Guardian(s)

Name (First and Last) | Relationship to Client

Phone | Email

Name (First and Last) | Relationship to Client

Phone | Email

Insurance Information

Insurance Company Name | Phone

Company Address | City | State | Zip

Member ID | Group #

Policy Holder Name (First and Last) | Policy Holder D/O/B | Relationship to Client

Person Responsible for Payment

Name (First and Last) | Relationship to Client

Address | City | State | Zip

Phone Number | Email

_____ *INITIAL* I authorize Partners in Pride® to release to the above insurance company's information needed for claims reimbursement. I hereby assign, transfer, and set over to Partners in Pride® my rights, title, and interest to medical reimbursement benefits under my insurance policy with the above documented insurance companies.

Comments

Partners in Pride®
WELLNESS CENTER

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Psychotherapist-Patient Services Agreement

This document contains important information about our professional services and business policies. Please read it carefully and feel free to discuss any questions you have with your therapist so as to ensure complete understanding of the document. When you sign that you have received and read this document, it will represent an agreement.

Psychotherapy Services

In our therapeutic work, we first and foremost understand that each patient is an individual with unique developmental, cultural, and life experiences that can affect their current ways of relating to others, their cognitions, and their patterns of behavior. Our work reflects an integrative approach, where we combine deeper exploration of emotions with more active techniques to provide symptom relief. As such, there are many different methods we may use to help you work on the problems you hope to address. At the foundation of our work, we provide Cognitive Behavioral Therapy and Client-Centered Therapy. We believe that each person has within him/her/themself the vast resources for self-understanding and personal growth. Each person has the ability to alter self-concepts, attitudes, and self-directed behaviors. If we can provide a facilitative relationship with certain definable psychological attitudes, the person can draw upon these resources. This approach has been found to be effective for individuals of all ages, couples, and families. Since therapy involves a personal look at aspects of your life experience, it requires you to be an active participant. In order for therapy to be most successful, you will have to work on things we talk about both during session and at home.

Professional Fees:

Each therapy session will last approximately 45 – 55 minutes. The number of sessions needed depends on many factors and will be discussed with you individually. Typically, sessions are scheduled for once a week, but are also available more or less frequently, depending on your individual needs. The initial session will include a diagnostic interview where your therapist will obtain information about your background, reason for seeking treatment, and personal goals and needs. The fee for the Diagnostic Interview is $250.00. The hourly fee for individual psychotherapy services is $165.00 (45 min) or $200.00 (55 min). (Please see separate fee document for additional services and fees.) You will be responsible to pay the amount for services at the time of service. If we are a provider with your insurance company, and you choose to utilize your insurance plan, we can bill your insurance company. You will be responsible to pay the co-pay portion for services at the time of

service. In addition, you will be responsible for any portion of the charges that are not covered by your insurance company.

Contacting Your Therapist:

Your therapist oftentimes will not be immediately available by telephone. When they are unavailable, calls are answered by confidential voicemail; your therapist will make every effort to return your call within 24 hours, with the exception of holidays. It is best to leave times when you are most available to be reached. If your therapist will be unavailable for an extended period of time, we will provide you with the name of a colleague to contact, if necessary.

If you are experiencing an emergency, please call 911 or go the nearest emergency room and ask for the psychologist (or psychiatrist) on call.

Use of Insurance:

In order to set realistic treatment goals, it is important to evaluate what resources you have available to pay for your treatment. If we are a provider with your insurance company, and you decide to utilize insurance to cover the cost of services, you should contact your insurance company to discover what your mental health coverage provides. Mental health coverage is usually different than physical health coverage. Please ask if you need pre-certification, what your co-pay is, and how many sessions you are allowed in what period of time. We provide the courtesy of billing your insurance company, if we are a provider with that company, and ask for you to make your co-payment at the time of service.

Ultimately, you are responsible for full payment of fees that your insurance company does not agree to cover. Therefore, it is important for you to fully understand your mental health benefits.

Confidentiality:

Illinois law protects the privacy of all communications between a patient and a therapist. In most situations, if you are 18 years of age or older, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois law. However, in the following situations, no authorization is required:

- Consultation with other health and mental health professionals. During these consultations, every effort is made to avoid revealing the identity of the patient.
- Disclosures required by health insurers or to collect overdue fees (as discussed elsewhere in the Agreement).

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-patient privilege law. We cannot disclosure any information without a court order.
- If a government agency is requesting the information for health oversight
- In malpractice suits.
- In Workman's Compensation Claims.

Psychotherapists are mandated reporters, and as such, we have the legal obligation of notifying appropriate authorities in the following situations. These situations are handled with the utmost care to protect those at risk for harm and with respect to the patient's broken confidentiality.

- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself, your therapist may be required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.
- If you have made a specific threat of violence against another, or if your therapist believes that you present a clear, imminent risk of serious physical harm to another, your therapist may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization.
- If your therapist has reasonable cause to believe that a child, under age 18, known to me in my professional capacity, may be abused or neglected by a parent, caretaker, or other person responsible for the child's welfare. The law requires that your therapist file a report with the local office of the Department of Children and Family Services.
- If your therapist has reason to believe that an adult over the age of 60, or under 60 and disabled, has been abused, neglected, or financially exploited in the preceding 12 months. The law requires that your therapist file a report with the agency designated to receive such reports by the Department of Aging.

If such situations arise, your therapist will make every effort to fully discuss these disclosures with you, and will include you in the process of disclosure if at all possible.

After reading this document, please sign the separate Signature Page, to certify that you have read the information in this document and agree to abide by its terms during our professional relationship.

Psychotherapist-Patient Services Agreement Signature Page

Signature of Client (for clients age 12 and older)	**Date**
Signature of Parent/Legal Guardian	**Date**

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Fees for Services

Out-of-Pocket Fees for Self-Pay

- Diagnostic Evaluation - $250
- 45 minute Individual Session - $165
- 55 minute Individual Session - $200
- Family or Couples Session - $200

Fees Not Covered By Insurance

These fees will be your sole responsibility, if applicable.

- No-Show/Fail Fee (This fee is implemented if less than 24 hours notice of cancellation is given, unless it is an emergency.) - $75 (1st time); $100 (2nd time); $150 (3 plus times)
- Letters - $75 (If the letter is more complex in nature, there may be additional fees added at the discretion of the therapist.)

Signature of Client (for clients age 12 and older) **Date**

Signature of Parent/Legal Guardian **Date**

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Consent for Treatment of a Minor and Receipt of Therapist-Patient Agreement Privacy Practices

I, the parent/legal guardian of the minor, give my permission for the minor to receive treatment provided by the therapist named herein.

This therapist's office policies concerning HIPAA, limits of confidentiality, the minor's rights as a patient, services, scheduling, fees, missed appointments, and emergency policies have been explained to me and are the same as with an adult client.

I have been told about the risks and benefits of receiving these services and the risks and benefits of not receiving these services, for both this minor and his or her family. I understand that no promises have been made to me as to the results of treatment or any evaluation provided by this therapist.

I am aware that I may stop treatment or evaluation with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel and do not show up, I will be responsible for a fee of $75, which is not reimbursable by my insurance.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments the minor receives from Partners in Pride® Wellness Center, in order to assure benefits.

This agreement also shows my commitment to pay for services. I agree to pay the full disclosed amount per session, and to pay at each session. I understand and accept that I am fully responsible for this fee, but that my therapist will help me in obtaining payment from my insurance coverage.

My signature below shows that I understand and agree with all of these statements.

Signature of Client (for clients age 12 and older)	**Date**
Signature of Parent/Legal Guardian	**Date**

Your signature below indicates that you have received the Psychotherapist-Patient Services Agreement and the Notice of Privacy Practices, and that you agree to abide by its terms during our professional relationship. These documents represent an agreement between us. You may revoke this agreement in writing at any time. However, revoking either of these two agreements will result in termination of professional services to you by Partners in Pride® Wellness Center. My signature below shows that I understand and agree with all of these statements.

Signature of Client (for clients age 12 and older)	**Date**
Signature of Parent/Legal Guardian	**Date**

This is a strictly confidential patient medical record. Rediscloure or transfer is expressly prohibited by law.

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH, ALCOHOL & DRUG ABUSE, AND OTHER PERSONAL HEALTH INFORMATION

I,_____, hereby authorize Partners in Pride® Wellness Center
(Patient/Parent/Guardian/Power of Attorney) (Facility/Therapist/Counselor)

to exchange\release any and all records or information regarding_____
(Name of Patient)

Mental Health Info
(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be **checked and initialed** to be included in the use and/or disclosure of other health information:

☐ ____ HIV / AIDS related treatment
☑ ____ Mental health information
☐ ____ Psychotherapy notes
☐ ____ Sexually transmitted diseases
☐ ____ Drug/alcohol diagnosis, treatment/referral.

to _____
(Receiving Agency/person) (Address)

For the purpose of: (please check all that apply)

☑ Continuing (health and mental health) treatment or care and continuity of care
☐ Therapist transition
☐ Housing and other arrangements and services
☐ Billing, payment and financial matters and arrangements
☐ Consultation, advise and representation regarding my condition and needs
☐ Other _____

This consent is valid until **(calendar date)** _____
I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclosed it without my written authorization.

I also understand that if I refuse to consent to this release of information the following may occur _____
Partners in Pride® will be unable to bill insurance. Client will be responsible for full fee for services.

_____ _____ _____
(Minor recipient, 12-17 yrs. Inclusive) **(Signature of adult patient or parent)** (Date)

_____
(Witness)

NOTICE TO PATIENT AND RECEIVING AGENCY:

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, HIPAA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.

REVOCATION OF AUTHORIZATION

The undersigned hereby revokes the above authorization for disclosure.

_____ _____
(Patient, parent, guardian) (Witness)

_____ _____
(Authorized agent - Power of attorney attached) (Date)