D'Amico & Associates in Counseling, LLC

Counseling/Advocacy/Consultation
Services for Children and Adults
www.DAmicoCounseling.com

15750 S. Bell Road, Suite 1A
Homer Glen, IL 60491

Hours by Appointment Only
(855) 223-HOPE

CLIENT INTAKE

Date: _____

Client Name: _____ DOB: _____

Parent/Guardian: _____ DOB: _____

Street Address: _____

City/State/Zip: _____

Phone: H_____W_____C_____

Email: _____

Party Responsible for Payment: _____

Referral Source: _____

Current Medication: _____

_____

Previous Treatment/Therapy: _____

_____

Presenting Concern: _____

_____

Complete if Applicable

Attorney Name: _____

Address: _____

Phone & Fax: _____

Please be advised that participation in court-ordered services will reduce the limits of confidentiality observed between this therapist and the court system. Medical privacy protection under HIPAA is guaranteed. Session compliance and recommendations may be required from the GAL or children's attorney.

_____(Initial understanding)

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INSURANCE INFORMATION

Client Name: _____ DOB: _____

Name of Insured: _____ DOB: _____

SS: _____

Employer: _____

Insurance Carrier: _____

Insured's ID #: _____

Group #: _____

Claim Address: _____

_____

AUTHORIZED PERSON'S SIGNATURE:

I authorize the above named provider to release any information necessary in processing this claim.

_____

Signature of Client or Parent of Minor Child Date

I authorize payment of medical benefits to this provider for services rendered (attachment).

_____

Signature of Client or Parent of Minor Child Date

HIPAA NOTICE OF PRIVACY PRACTICES

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

Effective date: September 1, 2009

D'Amico & Associates in Counseling, LLC has been and will always be totally committed to maintaining clients' confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

This notice describes my policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants and potential referral sources.

PAYMENT: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS: We may need to use information about you to review my treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services; If you provide information that informs us that you are in danger of harming yourself or others; Information to remind you of /or to reschedule appointments or treatment alternatives; Information shared with law enforcement if a crime is committed on our premises or against our staff or with child reps/GALs for compliance purposes as required by law such as a subpoena or court order. Court-ordered services are typically limited in their protection of confidentiality.

COURT-ORDERED SERVICES: Court-ordered visitation, mediation, and evaluations require periodic and final report/recommendations. Your verbal communications and session records may be available through a court order. Please know that only the information pertinent to the court's proceedings will be released. Court-ordered counseling allows session confidentiality; but may require participation verification and recommendations. We will request you to sign a consent to release any private communications to the court; however, the law requires my compliance in providing information which is subpoenaed or ordered released by a judge.

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INFORMED CONSENT

Thank you for choosing D'Amico & Associates in Counseling, LLC as your service provider. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. I, Terry Lee D'Amico, MA, LCPC have earned a Bachelor of Science Degree in Psychology from DePaul University and a Masters Degree in Counseling from Governors State University. I am licensed by the State of Illinois as a Licensed Clinical Professional Counselor. I have over 20 years of clinical experience in treating children, adolescents, adults and families using individual and family therapy. I use cognitive- behavioral therapy for most conditions, including, but not limited to addictions, anxiety, depression and PTSD; although other treatment approaches are used depending on the person or condition. My associates are also Master's degreed and licensed by the State of Illinois. Individual, marital and family therapy sessions are 45-50 minutes. Play therapy and young children's sessions are 30-40 minutes. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with our staff psychiatrist; b) information (diagnosis and dates of service) shared with your insurance company to process your claims; c) information you and/or you child or children report about physical or sexual abuse, then, by ILLINOIS State Law, we are obligated to report this to the Department of Children and Family Services; d) where you sign a release of information to have specific information shared ; e) if you provide information that informs us that you are in danger of harming yourself or others; f) information necessary for case supervision or consultation; g) ***recommendations and compliance reports in the case of court-ordered services;*** and h) when required by law (such as in Elder Abuse). If an **emergency situation** for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to **contact the emergency services in the community (911)** for those services. D'AMICO& ASSOCIATES will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s)_____Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I / We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s)_____Date_____

May we contact you at home (circle one) yes no? May we contact you at work yes no?

May we contact you by cell phone yes no?

Where may we contact you _____?

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FINANCIAL/INSURANCE ISSUES: As a courtesy our staff will bill your insurance company, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we will need to ask that you pay for services when rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to TERRY LEE D'AMICO, MA, LCPC.

I have received a copy of the fee schedule _____ (Initials)

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed at the hourly rate. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You may have a copy of this form if requested.

*Signature(s)*_____*Date*_____

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no inform will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME:_____

CLINIC:_____

ADDRESS:_____

PHONE:_____

*Signature(s)*_____*Date*_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I / We

consent that _____ may be treated as a patient by D'AMICO & ASSOCIATES. At times it maybe necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____Date_____

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FEE SCHEDULE

Initial Consultation	$225.00/Session
Individual Counseling	$150.00/Session
Family Counseling	$250.00/Session
Couples Counseling	$200.00/Session
Play Therapy Session	$150.00/Session
Phone Contacts	$40.00/Qtr. hour
Psychological Testing	Varies
Diagnostic Evaluation	Varies
File Reproduction	$0.25/page
Treatment Summary	$25.00
Returned Check Fee	$50.00
Visitation	$90.00/Hr.
Off-Site Visitation	$150/Hr (plus therapy expenses)
Therapeutic Visitation	$175/Hr.
Reunification Services	$175/Hr.
Mediation	$200.00 and up/Session
Home Study	$1100.00 and up
Evaluation	$1500.00 and up
Court Report	$250.00 and up
Deposition	$275.00/Hr. – 2-hour minimum (travel extra)
Attorney Consultation	$200.00/Hour (travel extra)
Court Appearance	$750.00/Hr. – 2-hour minimum (travel extra)

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December 1, 2015

Dear Clients:

A new year and new deductibles will soon be upon us. We ask that you be aware of your insurance changes which will become effective January 1, 2016.

Everyone who will be insured at the start of 2016 will either receive or have electronic access to a certificate of insurance which explains their insurance coverage (40% / 50% / 60% / 70% / 80% / 90%) plus annual deductibles, co-pays and co-insurance amounts.

At your first appointment in January, please be prepared to present your therapist with a copy of your new insurance coverage, your new insurance card and identification, as well as payment for the session. You will be required to pay for each session until we receive proof from your insurance company that your deductible has been met. Since the new law requires everyone to carry insurance, we will need this information from you even if your sessions are being subsidized by a third party.

If you have any questions about our new policy, please speak with your therapist.

Thank you for your cooperation and attention to these matters.

Sincerely,

TerryLeeDAmico

Terry Lee D'Amico, MA, LCPC