

*D'Amico & Associates in Counseling*

**Client Intake**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian Name (if under 18 years old): \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address (include apt/unit # if applicable): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Home Phone (if available): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_

.....  
Name of Party Responsible for Payment: \_\_\_\_\_

.....  
Referral Source: \_\_\_\_\_

Current Medication: \_\_\_\_\_

.....  
Previous Treatment/Therapy: \_\_\_\_\_

.....  
Presenting Concern: \_\_\_\_\_

.....  
(Complete if applicable)

Attorney Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

.....  
**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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<b>Insurance Information</b>
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Client Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_\_

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**Insured's Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_

Member ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Claim Address (back of card): \_\_\_\_\_

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I authorize D'Amico & Associates in Counseling to release any information necessary in processing this claim. Additionally, I authorize payment of medical benefits to this provider for services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Notice of Privacy Practices**

Effective date: September 1, 2009

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

D'Amico & Associates in Counseling, LLC has been and will always be fully 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 the 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 use or disclose health information about you to provide, manage or coordinate your care or related services. This could include consultants and potential referral sources.

**Payment:** Information about you will be necessary to verify insurance coverage and/or benefits with your insurance carrier to process your claims, as well as information needed for billing 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 may be used for certification, compliance and licensing activities.

**Other uses or disclosures of your information which do not require your consent:** There are some instances where we may be required to use and disclose information about you without your consent. For example, but not limited to: Information you and/or your child(ren) 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 representatives/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 our compliance in providing information which is subpoenaed or ordered released by a judge.

**I have read the Notice of Privacy Practices and understand its content.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Informed Consent**

Thank you for choosing D'Amico & Associates in Counseling, LLC as your service provider. Your first 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 do our best to provide you with all the information you may 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 may be used depending on the person or condition. My associates have also earned their Masters Degree and are 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 at your first appointment.

**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 your child(ren) 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 Elder Abuse). If an **emergency situation** occurs 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.

**I have read the Informed Consent and understand its content.**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*D'Amico & Associates in Counseling*

<b>Client Contact</b>
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(Please circle one)

May we contact you by cell phone, and leave a voicemail if necessary?    YES                    NO

May we contact you at work, and leave a voicemail if necessary?    YES                    NO

May we contact you at home, and leave a voicemail if necessary?    YES                    NO

If you answered no to all of the above, where may we contact you? \_\_\_\_\_

*D'Amico & Associates in Counseling*

**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 copay 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.** \_\_\_\_\_ (initial)

If you need to cancel or reschedule an appointment, please give 24 business hours advanced 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: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**COORDINATION OF TREATMENT:** It is important that all healthcare 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 information will be shared.

(Please check one)

**You may inform my physician(s)**                       **I decline to inform my physician(s)**

Physician Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Consent for Treatment of Children or Adolescents**

Separate forms are required for each child

I/We consent that \_\_\_\_\_ (DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_) may be treated as a patient by D'Amico & Associates in Counseling.

We ask for your cooperation to provide the most timely treatment for you and your child.

I understand that I have the right to revoke this consent, in writing, at any time by sending notice to D'Amico & Associates in Counseling. I understand that a revocation is not valid to the extent that D'Amico & Associates in Counseling has acted in reliance on such authorization.

\_\_\_\_\_ (initial)

Client Signature (12 years or older): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent 1 Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship: \_\_\_\_\_

Parent 2 Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship: \_\_\_\_\_