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: ()- Email address:

**Please be advised that participation in court-related 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)**

**(Initials of minor client (12+ yrs. old))**

Insurance Information

Client Name: DOB://

Social Security Number: *-     -*

**Insured’s Information**

Name: DOB://

Social Security Number: *-     -* Phone:()-

Employer:

Insurance Carrier:

Member ID: Group ID:

Claim Address (back of card):

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: //

Client Contact

(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?

Notice of Privacy Practices

Effective date: December 8, 2022

**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-related services are typically limited in their protection of confidentiality.

**Court-Related Services:** Court-ordered visitation, mediation and other court-requested 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-related 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://

**Minor Client Signature (12+ yrs. old):** Date: //

Informed Consent

Welcome and thank you for choosing D’Amico & Associates in Counseling as your service provider. Please read the practice policies (especially about confidentiality and financial protocols) and bring any questions you may have to your therapist. This document is intended to inform you of the rules and regulations all therapists must follow while providing client services.

Therapy often involves discussing unpleasant aspects of your life and you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Therapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress; however, there are no guarantees as to what you will experience.

Sessions last between 50-60 minutes and various treatment practices/philosophies are used depending on the issues you bring to your therapist. Therapy requires your participation in your sessions. In order for therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. We are here to support you and assist you in improving your quality of life.

**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-related services**; and h) when required by law (such as Child or 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://

**Minor Client Signature (12+ yrs. old):** Date: //

**FINANCIAL/INSURANCE ISSUES:** As a courtesy, our staff will bill your insurance company, responsible party, or third-party payer for you. You are required to pay co-pays/co-insurance, deductibles, and self-pay fees at the time of service. We ask that every client authorize payment of medical benefits directly to **Terry Lee D’Amico, MA, LCPC.**

**If you need to cancel or reschedule an appointment, please give 24 hours’ advanced notice. No call/no show or late cancellations (less than 24 hours’ notice) will be billed at the hourly rate.** We sincerely appreciate your cooperation and if 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://

**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://

**Minor Client Signature (12+ yrs. old):** Date: //

Consent for Treatment of Children or Adolescents

Separate forms are required for each client/child

I/We consent that **(name of minor)**  (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)**  **(initials of minor (12+ yrs. old))**

**Client Signature (12+ yrs. old):** Date://

**Witness Signature:** Date: //

**Parent 1 Signature:** Date://

Relationship:

**Parent 2 Signature:** Date://

Relationship:

Informed Consent to Telehealth

Separate forms are required for each client/child

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: Counselor:

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and adult-dependent abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to D’Amico & Associates in Counseling. My signature below indicates that I have read this Agreement and agree to its terms.

**Signature:**       Date: //

**Minor Client Signature (12+ yrs. old):** Date: //

Reciprocal Consent to Release/Receive Confidential Information

**I/We, , give my/our informed consent for D’Amico & Associates in Counseling to release and receive confidential information to:**

Name of **Professional/GAL/Attorney** to receive information:

Phone: ()- Fax: ()-

Agency Name:

Address:

City:  State:  Zip Code:

**For the purpose of coordination of services.**

Client Name: DOB://

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

City: State: Zip Code:

**This consent is valid for one (1) year from today’s date, unless revoked in writing.**

I have read and understand the purpose of this release is to coordinate treatment services.

**Signature:** Date: //

**Minor Client Signature (12+ yrs. old):** Date: //

**Witness Signature:** Date: //

Payment Authorization Form

Please complete all fields, print, and sign the bottom of this page. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

|  |  |
| --- | --- |
| **Billing Information (REQUIRED)** | |
| Billing Street Address |  |
| Billing City, State, & Zip Code |  |
| Billing Email Address |  |
| Billing Phone Number |  |

**PLEASE COMPLETE ONE OR BOTH FOR YOUR CHOICE OF PAYMENT.**

|  |  |
| --- | --- |
| **Credit Card Information** | |
| Card Type | (select one) |
| Cardholder Name  (as it appears on card) |  |
| Card Number | -     -     - |
| Expiration Date |  |
| CVV (3-digit code) |  |

I, , authorize D’Amico & Associates in Counseling to charge my credit card for agreed upon services. I understand that a **convenience fee** will be added to each credit card transaction (fee schedule available upon request). I understand that my information will be saved to file for future transactions on my account.

|  |  |
| --- | --- |
| **Checking Account Information (for E-Checks)** | |
| Account Holder Name  (as it appears on checks) |  |
| Routing Number |  |
| Account Number |  |

I, , authorize D’Amico & Associates in Counseling to charge my e-check account for agreed upon services. I understand that a **convenience fee** will be added to each e-check transaction (fee schedule available upon request). I understand that my information will be saved to file for future transactions on my account.

Agreed upon services for the following clients are authorized to be charged to this credit card or E-check account:

|  |  |
| --- | --- |
| **Authorized Client List** | |
| (Client Name) | (Client Name) |
| (Client Name) | (Client Name) |
| (Client Name) | (Client Name) |

**Signature:**       Date:      /     /