CHICAGO CHRISTIAN COUNSELING CENTER

PRELIMINARY INTAKE INFORMATION

Please provide the information requested in the spaces provided. This and all other information relating to your association with Chicago Christian Counseling Center is regarded as strictly confidential and will not be shared with anyone without your signed consent. (Please print legibly)

Client____Date_________________________

Address_______________________________City_____________State______Zip_________

Phone_________________________________Alternate________________________________

Social Security #________________________________ Email __________________________

DOB___/___/____ Age__________ Sex (M/F)________

Marital Status: S M Sep D W

Please provide parent/guardian information if client is a minor, or 2nd party information if couple counseling.

Name____________________________________ Relationship___________________________

Address (if different from above)____

City____________________State_____ Zip__________ Phone (___)______________________

DOB___/___/____ Age______ Sex (M/F) _______ SS#___________________________

Church Affiliation (if any)_________________________Denomination_____________________

Primary Care Physician__________________________ Phone (_____)___________________

Employer/School (if any)____

I wish to receive Chicago Christian Counseling Center mailings. Yes______ No______

Who referred you to Chicago Christian Counseling Center?

€ Ad/Newspaper	Ad/Radio	Attorney	Cath Charities	Bethany	Current/Past Client
Doctor	Drive By	Employer	Family Member	Friend	Hospital
Insurance	Internet	New Leaf	None	Pstor/Chrch	School
Spouse	Therapist	Frmr Thrpst	Victorian Village	Yellow Pgs	Other Professional
Other____________________				

EMERGENCY INFORMATION

Emergency Contact___________________________________ Relationship________________

Address______________________________City__________________State_____Zip_______

Home Phone______________________________Alternate___________________________

BILLING INFORMATION

The office staff will copy your insurance card(s) to ensure proper filing of claims.

Primary Insured ______________________________DOB ___/___/___ SS#__________________

Relationship to Client € Self € Spouse € Parent € Other________________

Employer________________________________

Primary Insurance Carrier _____________________________ Phone ( ) __________________

Claims Address____

ID#____ Group#_________________________________

Secondary Insured __________________________DOB ___/___/___ SS#________________

Relationship to Client €Self €Spouse €Parent €Other______________________

Employer____

Secondary Insurance Carrier ________________________ Phone ( ) ____________________

Claims Address____

ID#____Group#______________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the Chicago Christian Counseling Center to (A) furnish information concerning my diagnosis and treatments to my insurance carrier(s) and (B) request my insurance carrier(s) to direct payment to the Chicago Christian Counseling Center.

Client/Authorized Person's Signature:________________________________Date _____________

CONFIDENTIALITY

All information regarding clients is considered strictly confidential and will not be given to anyone without your written consent. In the event of a request for the transfer of records to another party, the records will be forwarded directly to that party only upon receipt of your written request.
I give my consent to_________________________(therapist) to provide evaluation and treatment that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

Client
Signature____Date_______________________

Parent/Guardian
Signature____Date_______________________

OFFICE & FEE POLICIES

Thank you for choosing us as your counseling services provider. We are committed to helping you reach your goals. We ask that you commit yourself to the timely payment of your agreed upon portion of the charge. The following is a statement of our financial policy:

- We require payment in full at the time of service unless prior arrangements have been made with your healthcare professional. HMO, PPO, and Medicare clients are expected to pay the co-payment portion at the time of service
- We accept cash, checks, Visa, Mastercard, or Discover.
- There will be a $15.00 charge for any returned check.
- As a service to you, whenever your insurance company will work with us, we will process your insurance claims.
- Benefits payable are determined by the insured's eligibility, the limitations, exclusions and conditions of the plan. Benefits are determined at the point the claim is processed.
- **Insurance quotes by our staff are not a guarantee of benefits. If you have questions regarding your benefits, please call your insurance company directly.**
- **If insurance does not pay, all agreed upon expenses will be the responsibility of the client.**
- **It is the responsibility of the client to notify this office when an appointments must be broken (24 hour prior notice), or the session will be billed to you at the regular one-hour fee.**
- Account balances, which remain unpaid for more than 90 days, may be forwarded to collection agency. The client will bear the full cost of collection activity and any legal fees incurred.

I have read and I understand the above policies.

Financially Responsible Party____

Address___________________________City_______________State____Zip_______

Phone__________________________________Alternate________________________________

SS#_______________________________________DOB____/_____/______

Signature____ Date________________

OFFICE USE ONLY:

Therapist: ____

Office Location € CHI € CRE € DEM € EP € OAK € OP € LOM

€ MOK € NLI € PLF € SH € IN € WAU

SYMPTOM CHECKLIST A
(primary client or parent/guardian of minor)

Name____________________________________ Date____________________

Statement of problem(s) for which you now seek counseling:
____
____
____
____
____

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	Never	Sometimes	Often
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

Many insurance companies require their policyholders to answer the following questions. Failure to answer these questions may result in a delay in processing your claims.

When did the symptoms first begin?_____/_____/_____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)

SYMPTOM CHECKLIST B
(Spouse or Minor)

Name_________________________________ Date____________________

Statement of problem(s) for which you now seek counseling:
____
____
____
____

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	Never	Sometimes	Often
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

Many insurance companies require their policyholders to answer the following questions. Failure to answer these questions may result in a delay in processing your claims.

When did the symptoms first begin?_____/_____/_____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)

15127 SOUTH 73RD AVENUE, SUITE G, ORLAND PARK, ILLINOIS 60462

Tel. 708/845-5500 Outside A.C. 708-DIAL 800/361-6880 Fax 708/845-5505
Web Address: www.chicagochristiancounseling.org
Email Address: info@chicagochristiancounseling.org

ILLINOIS NOTICE FORM

Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH 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 for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another mental health provider.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within the Chicago Christian Counseling Center, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of the Chicago Christian Counseling Center, such as releasing, transferring, or providing access to information about you to other parties, or mental health provider within the Chicago Christian Counseling Center.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or a neglected child, I must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* – If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.

- *Health Oversight Activities* – I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary actions.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

- *Worker's Compensation* – I may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and the Mental Health Provider's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications 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 not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)

708/335-0957 815/485-1911 630/990-1935 708/845-5500 219/864-4363 708/596-9555

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Provider's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

- If I revise my policies and procedures, I will provide a written notice regarding any changes and mail them to you.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Janet Lundgren, Psy.D., Licensed Clinical Psychologist and Privacy Officer for Chicago Christian Counseling Center at (708) 845-5500, ext. 108.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to Janet Lundgren, Psy.D., Chicago Christian Counseling Center, 15127 S 73rd Avenue, Suite G, Orland Park, IL 60462-3425.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail.

I have provided my client with a copy of the above Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of my Health Information.

____ Date: _______________________

Signature – Mental Health Provider

I have read and received a copy of the above Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of my Health Information.

X____ Date: ____________________

(Recipient Age 12 or over)

X____ Date: ____________________

(Parent/Guardian of minor or guardian of a legally disabled recipient)

If the signature is not the Recipient's, indicate the legal relationship to the recipient:

____

X____ Date: ____________________

(Witness)