Great Changes
Counseling Services

9435 Bormet Dr. #5 Mokena, IL 60448
Phone: 708-995-7226 Fax: 708-995-7227

Adult Client Intake Information

Today's Date: _____ Therapist's Name: _____

Client First Name: _____ Middle: ____ Last: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Mobile Phone: _____

Sex: _____ Marital Status: _____ Birth date: _____Email _____

Referred by _____

Will you be using **Employee Assistance Program** benefits for your initial sessions? **Y N**

If yes - Name of EAP Program – Ceridian Lifeworks Employee Resource Systems (ERS) Compsych
Cigna EAP Aetna EAP Magellan EAP
Other _____

How many sessions have been approved for EAP Services _____

Whose EAP benefit is this _____ Relationship to Client _____

EMERGENCY CONTACT Name & Number _____

Primary Insurance Policy Information:

Copy of Insurance Card must accompany this form – Therapist can copy it for you at first session.

Insured's Name: _____Birth date: _____

Address: _____

City, State, Zip: _____

Employer: _____

Patient's Relationship to the Insured: Self _____ Spouse _____ Child _____ Other _____

I authorize the release of any medical or other information necessary to process this claim.

.

Signed: _____ Date: _____

I authorize payment of medical benefits to Great Changes Counseling Services for services provided.

Signed: _____ Date: _____

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Notice of Privacy Practices - Summary

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. Though these laws are complicated, we must provide you with this important information. These two pages summarize the Notice of Privacy Practices which you may request from your provider and which you may refer to for more information. We realize that it is not possible to cover all scenarios in this document, so please consult our Privacy Officer, Owner Donna Welter if you have further questions or concerns.

The health information we will obtain will be documented primarily from you but may also include information obtained from other family members or professionals involved in your case that you have given us permission to speak with. This information will be used to provide you with effective treatment, to arrange payment for our services or for other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a form acknowledging that you have received this notice. If you are not willing to sign this form, we cannot treat you.

If information regarding your treatment here needs to be disclosed to others for family involvement or for coordination of treatment services we will discuss this with you and ask you to sign an Authorization to allow this.

We will keep all of your health information private. However, there are some situations where the law requires us to disclose information about you even without your signed consent, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

See the complete text of the NPP for the full list of mandated disclosure scenarios.

Your rights regarding your health information

1. You have the right to determine how we get in touch with you if we need to (for appointment changes or cancellations).

2. You have the right to determine what information is shared with others involved in your treatment.

3. You have the right to review your record and can request a copy of your record (medical and billing).

4. If you believe the information in your records is incorrect or incomplete, you can request that changes or amendments be made to them. This request must be made in writing and must include reasons for the request.

5. You have the right to receive a copy of this notice. If our Privacy Practices are changed, we will post a notice in our waiting room and a copy can be requested.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Donna Welter, phone number 708-995-7226 x102, 9435 Bormet Dr. #5, Mokena, IL 60448

The effective date of this notice is February 28, 2011.

Notice of Privacy Practices: Receipt and Acknowledgment of Notice

Patient/Client Name:_____**DOB**_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Great Changes Counseling Services Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Donna Welter at 708-995-7226

I verify that I understand the following:

All the information in my sessions is confidential **EXCEPT:**
If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused, then the therapist must tell someone to protect me or another.

Patient/Client Signature:_____**DOB**_____

Financial Policy

Fees for Professional Services

Great Changes charges the following usual and customary rates for face-to-face behavioral health services.

- $175 for a New Client Visit (Intake Evaluation) (code 90791)
- $175 for individual sessions longer than 53 minutes (code 90837)
- $125 for individual sessions lasting between 38-52 minutes (code 90834)
- $175 for couple or family sessions with more than one person present (code 90847)

48 hour cancellation fee Clients must give 48 hours notice when cancelling so that the therapist may try to fill that spot with another client. If a client misses an appointment or cancels late, the therapist may assess a $100 missed appointment fee.

Payment at time of service is expected for co-pays and self-pay clients.

Health insurance If your medical insurance covers behavioral health services, which most do, Great Changes will submit claims for reimbursement if you authorize them to. It is your responsibility to pay co-payments or co-insurance amounts or any fees applied to your deductible.

Insufficient funds In the event that any check I write is returned NSF (insufficient funds) I agree to pay a $15.00 service fee.

Authorization To Use Credit Card

For your convenience, you may authorize Great Changes to charge your credit card for balances due on your account. I authorize Great Changes Counseling Services, P.C. to keep my signature on file and to charge my credit or debit or HSA card for co-payments, co-insurance payments or deductible obligations that are not collected at time of service. Great Changes Providers will be collecting payments at each session whenever possible.

I understand that this form is valid only during the term of my treatment services at Great Changes, and that I can cancel the authorization through written notice to Great Changes at any time.

Name on Credit Card: _____
Client Name: _____
Credit Cardholder Address: ___ same as client address on Intake Sheet
Different Address associated with Credit Card _____
_____Zip Code_____

Email Address – necessary for our credit card processing site & receipt _____

Credit Card Account Number: _____ - _____ - _____- _____
Card Expiration Date: ___/____/____ 3-digit Security Code: _____

Cardholder's Signature: _____

Date: _____

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CONSENT TO TREATMENT

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by Great Changes providers.

I understand and agree to the above provisions

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

Patient/Client Refuses to Acknowledge Receipt:

_____ _____

Signature of Staff Member Date

SOCIAL MEDIA POLICY

Therapists at Great Changes will not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, Instagram, etc.). Adding clients as friends on these sites can compromise confidentiality and blur the boundaries of the therapeutic relationship.

Please do not use SMS or messaging on any social network site to contact your therapist. These sites are not secure and can compromise your confidentiality. You can always reach your Great Changes provider by calling the office number at 708-995-7226 and entering your provider's extension.

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Consent to release information to Primary Care Physician

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date is specified.

_____ _____

Patient Name Date of Birth

Please check one:

□ I agree to allow my Great Changes therapist to release mental health/substance abuse information to my Primary Care Physician.

□ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name:

_____

Physician Address:

_____

City, State, Zip:

_____

Physician Phone: _____ Fax: _____

_____ _____

Patient Signature Date

Information for PCP

This patient was seen by me on (date) _____

for (symptoms & diagnosis) _____

_____ _____

Provider Signature Date

_____

Provider Printed Name

Great Changes Counseling Services

Marital/Significant Relationship History

Partner's Name:_____ Partner's Age:_____

Partner's Occupation:_____ Employer:_____

Marriage Date:_____ My marriage is: □Great □Good □OK □ Fair □ Poor

Number of marriages:_____

Strengths of your present marriage/relationship:

_____

_____

Problems of your present marriage/relationship:

_____

_____

Children: Name:_____ Date of Birth:_____ Age:_____

Name:_____ Date of Birth: _____ Age:_____

Name:_____ Date of Birth:_____ Age:_____

Name:_____ Date of Birth:_____ Age:_____

Employment

Employer:_____

City:_ _____

Your position: _____ Length of Employment: _____

What (if any) problems do you have with your employment?

_____

_____

Military Service: **Y N**

Details**:** _____

Arrests **Y N** Convictions **Y N**

Details**:**_____

Symptom Check List (Please check all that apply)

☐ Financial difficulties ☐ Legal Problems ☐ Depression ☐Anxiety

☐ Voices in my head ☐ Suicidal thoughts ☐Attempts ☐ Crying Spells

☐ Difficulty with relationships ☐ Loneliness ☐Anger ☐ Loss of appetite

☐ weight gain ☐ weight loss ☐ Eating disorder ☐ Self Harm ☐ Mood Swings

☐ Memory loss ☐ Agitation ☐ Mental Illness ☐I have thought of hurting myself

☐ I have thought of hurting someone else ☐Previous psychiatric hospitalization

Previous Mental Health Treatment

If you have received mental health treatment/hospitalization in the past, please tell us:

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Provider: _____ When Seen: _____ Helpful? Y N

Previous Mental Health Diagnosis: _____

Medications You Are Taking:

_____

_____

_____

Medical History Check List

☐Hospitalizations ☐Surgeries ☐Prematurity ☐Asthma ☐Head Trauma ☐Heart Murmurs

☐Heart Palpitations ☐Fainting ☐Seizures ☐ Thyroid Disorder

☐Other: _____

_____

_____

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Alcohol & Drug Screen Questionnaire

1. Do you feel you are a normal drinker? ("normal" – drink as much or less than most other people) **YES NO**

2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening? **YES NO**

3. Does any near relative or close friend ever worry or complain about your drinking? **YES NO**

4. Can you stop drinking without difficulty after one or two drinks? **YES NO**

5. Do you ever feel guilty about your drinking? **YES NO**

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? **YES NO**

7. Have you ever gotten into physical fights when drinking? **YES NO**

8. Has drinking ever created problems between you and a near relative or close friend? **YES NO**

9. Has any family member or close friend gone to anyone for help about your drinking? **YES NO**

10. Have you ever lost friends because of your drinking? **YES NO**

11. Have you ever gotten into trouble at work because of drinking? **YES NO**

12. Have you ever lost a job because of drinking? **YES NO**

13. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking? **YES NO**

14. Do you drink before noon fairly often? **YES NO**

15. Have you ever been told you have liver trouble such as cirrhosis? **YES NO**

16. After heavy drinking have you ever had delirium tremens (D.T.'s), severe shaking, visual or auditory (hearing) hallucinations? **YES NO**

17. Have you ever gone to anyone for help about your drinking? **YES NO**

18. Have you ever been hospitalized because of drinking? **YES NO**

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? **YES NO**

20. Have you ever gone to any doctor, social worker, clergyman or mental health clinic for help with any emotional problem in which drinking was a part of the problem? **YES NO**

21. Have you been arrested more than once for driving under the influence of alcohol? **YES NO**

22. Have you ever been arrested, even for a few hours, because of other behavior while drinking? **YES NO**
(if Yes, how many times_____)

Alcohol & Drug Use

At what age did you have your first drink? _____ At what age did you first try a drug? _____

Current use: alcohol – frequency ____ daily ____ weekly ____monthly ____ none

amount each episode _____

drugs – frequency _____ daily ____weekly ____ monthly _____ none

drug of choice _____

Check any of the following that you have experimented with or used:

Valium or Xanax, _____ Sleeping Pills_____ Marijuana _____ Cocaine _____

Hallucinogens (LSD, STP, PCP) _____ Opiates (heroin, morphine, Demerol) _____

Ecstasy _____ Inhalants _____ other drugs ____ Over the counter medications _____

Do you smoke cigarettes or cigars **Y N** If yes, how long have you been a smoker _____?

What have you tried to quit_____ When _____