Finn Counseling, LLC

1580 S. Milwaukee Ave, Suite 502 Libertyville, IL 60048 Phone 224-725-3306

Intake Information

Date: _____

Client Name: _____

Marital Status:_____

Address: _____

City: _____ State:_____ Zip Code: _____

Date of Birth: _____ Age: _____ Gender/Preferred Pronoun: _____

Phone: Home:_____ Cell:_____ Work: _____

Employer: _____

Employer Address: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Insurance Information:

Company: _____ Phone: _____

ID or Policy #: _____ Group #: _____

Holder of insurance policy, if other than client: _____

Relationship to client: _____ DOB: _____

Person responsible for payment (if different than client):

Name: _____ Phone: _____

Address: _____

Referred by: _____

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Financial Policies and Agreement

Payment for services provided by Finn Counseling, LLC is due at the time services are rendered unless payment by health insurance has been arranged prior to the visit. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. Such payments may be made by cash, check, or credit card. I understand that I am responsible for all charges, regardless of insurance coverage.

Some services may not be covered by health insurance. This may include charges for telephone consultation, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. Limited telephone consultation is part of routine client care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied. Every effort will be made to notify you if such a charge is likely to occur. However, the exact amount charged cannot always be predicted.

A missed appointment fee will be charged as follows: $50 for missed appointments and other fees for appointments cancelled with less than 24 hour notice. A charge of $30 will be applied for all checks returned unpaid. If an overdue account is sent to a collection agency, collection fees and expenses will be added to the amount due. A copy of the currently applicable fee schedule of Finn Counseling, LLC is available upon request. Fees may be modified without notice.

Acknowledgement and Agreement
I have read the above and affirm that everything in this form that was not clear to me has been explained to my satisfaction. I understand that it is my responsibility to know my insurance benefits. I hereby agree to abide by the policies specified above and to be responsible for all fees and charges for services provided by Finn Counseling, LLC to or on behalf of the client named below. This agreement will continue as long as Finn Counseling, LLC provides services or until a written request that this agreement be terminated is received by Finn Counseling, LLC.

Assignment of Health Insurance Benefits: The signature below authorizes payment directly to Finn Counseling, LLC of benefits payable under the health insurance policy covering the client named below. A photocopy of this form is to be considered as valid as the original.

_____

Client's (or parent/guardian's) signature Date
Indicating agreement of all of the statements above

Printed Name_____

I also agree to be financially responsible for any charges not covered by insurance including charges for any missed appointments and/or late payments. In addition, I authorize my credit/debit card to be charged for any unpaid balance on my account including any required fees.

_____ _____ _____ _____

Name of Credit Card authorized to charge Credit Card number Sec. code Exp. Date

_____ _____

Signature of Client Date

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_____	_____	_____	_____
Name of Credit card authorized to charge	Credit card number	Sec. code	Exp. Date

_____ _____

Signature of Client Date

_____ _____

Signature of Guardian/Parent of Child Date

_____ _____

Signature of Witness Date

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Consent for Treatment

I, _____, hereby affirm that I am 18 years of age or older, and hereby give
(Client's name)
my consent to be treated and receive an assessment and/or mental health services from Finn Counseling, LLC clinical staff.

_____

_____

Client Signature Date

Consent for Treatment of a Minor (Under 18)
(Or Consent for Treatment of an Adult Who has a Legal Guardian)

I, _____, hereby affirm that I am the legal guardian of
(Legal Guardian's name)

_____, and hereby give my consent for him/her to receive an assessment
(client's name)

and/or mental health services from Finn Counseling, LLC clinical staff.

_____

_____

Guardian's Signature Date

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Client's Bill of Rights and Responsibilities

As a client receiving care or service from Finn Counseling, LLC, you have the right to:

- receive respectful treatment without discrimination
- receive a particular type of treatment or end treatment without obligation or harassment
- be treated in a safe environment, free from sexual, physical, and emotional abuse
- report unethical and illegal behavior by a therapist
- ask questions about your treatment
- request and receive full information about the therapist's professional capabilities, including licenses, education, training, experience, professional association membership, specialization, and limitations
- obtain written information about fees, methods of payment, insurance reimbursement, emergency and cancellation procedures.
- refuse to answer any questions or disclose any information you choose not to reveal
- know the limits of confidentiality and the circumstances in which a therapist is legally required to disclose information to others
- know if there are supervisors, consultants, students, or others with whom your therapist will discuss your case
- request, and in most cases receive, a summary of your file, including the diagnosis, your progress, and type of treatment
- request that a copy of your file be transferred to any therapist or agency you choose (a fee may be charged)
- receive a second opinion at any time about your treatment
- request that the therapist inform you of your progress

I, the undersigned, am a client of Finn Counseling, LLC. My therapist has shared the above policies regarding required disclosures with me and has explained their implementation and significance. I have been given a copy of this document, and fully understand it. I have also been advised that Finn Counseling, LLC has offered no guarantees as to the success, or as to a specific outcome, of my treatment.

Signed: _____ Print Name: _____

Date Signed: _____ Location: _____

Witness: _____ Title: _____

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Risks and Benefits of Psychological Treatment

The process of therapy: Participating in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Therapy can help facilitate positive growth and development that foster your best interest and welfare. Working towards these benefits; however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order for change to occur in your thoughts, feelings and/or behaviors. Your therapist will ask for your feedback and views on your therapy, its progress and other aspects of the therapy and will expect you to respond openly and honestly. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in you experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. or experiencing anxiety, depression, insomnia, etc. Your therapist may challenge some of your assumptions, perceptions or propose different ways of looking at, thinking about, or handling situations which may cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such aas personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy your therapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive behavioral, psychodynamic, existential, family/system, developmental (adult, child, family), or psycho-educational. If you have any unanswered questions about any of the procedures used in the course of your therapy, their risks, your therapist's expertise in employing them, or about the treatment plan, please ask, and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatments that your therapist does not provide, he/she has an ethical obligation to assist you in obtaining those treatments. Your therapist consults regularly with other professionals regarding his/her clients; however, clients' names or other identifying information are never mentioned. After the first couple of meetings, your therapist will assess if he/she can be of benefit to you. Your therapist does not accept clients who, in his/her opinion, he/she cannot help. In such a case, he/she will give you a number of referrals whom you can contact. If, at any point during psychotherapy or treatment, your therapist assesses that he/she is not effective in helping you reach the therapeutic goals, he/she is obligated to discuss it with you and, if appropriate, terminate treatment. In such a case, he/she would give you a number of referrals which may be of help to you. You have the right to terminate therapy or treatment at any time. If you choose to do so, your therapist can offer you names of other qualified professionals whose services you might prefer.

Signed: _____ Print Name: _____

Date Signed: _____ Location: _____

Witness: _____ Title: _____

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Disclosures Regarding Confidentiality Policy

Finn Counseling, LLC is a provider of mental health services and is regulated in part by the State of Illinois Department of Mental Health and Developmental Disabilities (DMHDD) Confidentiality Act. Communications which occur during sessions are protected by one of the most stringent confidentiality laws in the country. In this regard, no disclosures may be made to anyone (note exemptions below) without the express written permission of the client. This confidentiality law protects both the therapist and the client from improper disclosures of sensitive, confidential information. It is the policy of Finn Counseling to resist any attempts by persons or entities outside of the therapeutic relationship to obtain access to this important and sensitive material. There are, however, certain exceptions to this strong restriction on disclosure which we must obey pursuant to Illinois law. These exceptions are described below:

Neglect and Abuse of Children

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). We are mandated reporters, as are all mental health service providers. The only requirement is that the "provider" (that is, any clinician at Finn Counseling, LLC) have a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the provider, the law absolutely requires that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of Finn Counseling, LLC to first advise the client that the report will be made. Subsequent to a "mandated" report, the client, and possibly others, will be contacted by an investigator from DCFS. If the investigator confirms the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigator(s) conclude that no abuse or neglect has occurred, a letter will be issued indicating the claim is "unfounded". Finn Counseling, LLC has no choice but to make reports in these situations. The client should be aware that the statute provides for loss of our license if we do not make these reports. The statute also provides us absolute immunity from any criminal or civil liability in the event that such a report is made, even without the client's consent.

Duty to Warn of Physical Injury

The DMHDD Confidentiality Act also mandates us to "warn" any intended victim, where a patient disclosed to us in session that he or she intends to cause physical harm to a specifically identifiable victim. It is then our responsibility to take steps to notify the victim and/or local authorities and to provide enough information with which the authorities and/or the victim might prevent the harm from occurring. The "duty to warn" is now required in Illinois. THerefore, if a client discloses an intent to harm a specific person, we must either contact that person or the authorities, or both. These disclosures are also protected by an immunity provision in the law.

Acknowledgment of Client

I, the undersigned, am a client of Finn Counseling, LLC. My therapist has shared the above policies regarding required disclosures with me, and has explained their implementation and significance. I have been given a copy of this document and fully understand it. I have also been advised that Finn Counseling, LLC has offered no guarantees as to the success or as to a specific outcome of my trea

Signed: _____ Print Name: _____

Date Signed: _____ Location: _____

Witness: _____ Title: _____

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Authorization Form

Release of Confidential Health Information

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my therapist at Finn Counseling, LLC to release:

☐ any information regarding my care.

☐ certain information regarding my care, limited to:

_____

_____

This information should only be released to or obtained from

_____

_____Phone Number_____

☐ I am requesting my counselor to release this information for the following reasons: Continuity of care

☐ Other (if other, explain below)

_____

This authorization shall remain in effect until _____ .

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Finn Counseling, LLC address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

I understand I have the right to inspect the disclosed mental health information at any time.
I understand that Illinois law prohibits redisclosure of any information disclosed to the recipient pursuant to this authorization unless this authorization specifically authorizes such redisclosure.

_____ _____

Signature of Client Date

_____

Print Name

_____ _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided and it must be dated

_____ _____

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Signature of Witness Date