



Taking Control

Dr. James Jorgenson & Associates

106 S. Lincolnway Street, Suite F

North Aurora, IL 60542

Phone: (630) 801-1669 ~ Fax: (630) 801-1675

New Client Information

Please print neatly

Today's Date: ____

Client's Date of Birth: ____/____/____

Client's Full Name: _____
(First) (Middle Initial) (Last)

Parent/Legal Guardian Name: _____
(If client is under 18) (First) (Middle Initial) (Last)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Type (Cell/Home/Work): _____ Okay to Text: Y/N

Email Address: _____

Which number is best to contact you during daytime hours? Cell/Home/Work

Car Make, Model, & License Plate Number: _____

Emergency Contact Information

Name: _____

Relationship: _____

Contact #: _____

Family & Personal Information*Please print neatly***Marital/Relationship Status:****Mark the Appropriate Box:**

Married	
Single	
Widowed	
Divorced	
Never Married	
Domestic Partnership	

Name of current spouse or significant other (if applicable): _____

Date of Birth of insurance holder (mom/dad/spouse/significant other MM/DD/YYYY): _____

Lives with you (circle one): YES NO

Sexual and Gender Identity:**Fill in the Appropriate Information**

Sexually Identify As	
Prefer Not to Answer	
Gender Identity	
Pronouns	

Children:

Name	Age	Date of Birth	Lives at Home (Yes or No)

Other Household Members:

Name	Age	Relationship

TAKING CONTROL Procedural Guidelines

Please initial on the line next to each guideline to indicate you have read and understand it

_____ Therapy **sessions are typically 50 to 55 minutes** in length. However, the focus is on the client rather than adherence to a strict time slot. If longer is needed for a client and you are waiting, please be patient--you may need more time some days.

_____ **Last minute cancellations with less than 24 hour notice or failure to keep appointments will be billed to the client at the normal rate. This includes billing the client's insurance and any deductibles due.**

_____ Phone consultations are possible although it is sometimes difficult to get back to people immediately. **Phone consultations will be billed** in quarter hour intervals at the normal rate for that person or family.

_____ Any financial arrangements that need to be made **should be requested ahead of time or during the first meeting**. If special case certification is required through your insurance, be prepared to do so immediately after the first session or you may be responsible for a larger part of the cost until certification is obtained. Time spent by us to obtain certification will be billed to you in quarter hour increments.

_____ **If a co-payment is required with the client's insurance plan, it is expected to be paid at each session unless other specific arrangements are made.**

_____ Letters of explanation and/or reports can be supplied as necessary and will be billed in quarter _____ hour increments.

_____ Attendance at case staffings, hearings, or court appearances will be accommodated as necessary and will be billed in quarter hour increments.

Federal law and regulations protect the confidentiality of client's verbal communication and records maintained by Taking Control. Your verbal communication and clinical records are strictly confidential except for:

- a) Information (diagnosis and dates of service) shared with your insurance company to process your claims;
- b) Information you and/or your child or children report that results in the suspicion of neglect; physical abuse, sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services;
- c) Where you sign a release of information to have specific information shared;
- d) If you provide information that informs me that you are in danger or harming yourself or others;
- e) Information necessary for case supervision or consultation;
- f) When required by law, such as an issuance of a court order;
- g) Information involving the suspicion of abuse of an elderly person;

Violation of the Federal law and regulations by a practice is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a client either at the practice or against any person who works for the practice or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect being reported under State law to appropriate State or local authorities.

(See U.S.C. 290odd-3 and 42 U.S.C. 290ee-3 for Federal laws and 42 CFR part 2 for Federal regulations)

THIS SUMMARY OF TAKING CONTROL'S PROCEDURAL GUIDELINES AND MY RIGHTS OF CONFIDENTIALITY HAS BEEN REVIEWED. I AM ENTITLED TO A COPY AND MAY RECEIVE A COPY OF THE ABOVE STATED PAPERWORK UPON REQUEST.

Client Signature: _____

Date: _____

Guardian Signature (If applicable): _____

Date: _____

Therapist Signature: _____

Date: _____



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Client Information and Privacy Practices

We are providing this information to answer questions clients may have about their care. We hope that you will take the time to read through the following information to familiarize yourself with our policies and procedures.

If you have any questions about the material, please feel free to contact us or ask your therapist so that your questions are answered. We look forward to working with you and providing the services necessary to achieve your treatment goals.

Services

Individual, Couple, Marriage, and Family Counseling

For children, adolescents, and adults

Abuse, Anger Management and Domestic Violence Therapy

For children, adolescents, and adults

Substance Abuse Treatment and Counseling

For adolescents and adults

Depression, Anxiety, ADD/ADHD, and Co-dependency Therapy

For children, adolescents, and adults

Mentoring/Respite Services

For children and adolescents

After-School and Summer Day Camp Programs

For children and adolescents

Not all services may be covered by all insurance or managed care plans. Please contact your health plan or insurance company for coverage and eligibility details.

TAKING CONTROL

Client Information and Privacy Practices

Patient Rights

You have the right to accessible, compassionate, and competent care.

Accessible:

We carefully monitor waiting times for routine appointments in order to accommodate you, typically within two weeks. Furthermore, we have designed an appointment system to accommodate you if you face an urgent or emergency need for service.

We understand that emergencies may arise during holidays and after normal office hours. Should you feel that you

are experiencing a psychiatric or psychological emergency or a serious reaction to medication treatment you are receiving, please contact the emergency telephone number on the business card of your therapist. A therapist for these emergency situations is available by phone 24 hours a day.

Compassionate:

You have the right to expect that your dignity will be preserved. You have the right to expend courteous attention from the office support staff.

You have the right to request a change in provider or a second-opinion consultation if you feel that the current services are not working to your expectations.

Competent:

Licensure of therapists and continuing medical education requirements ensure excellence of caregivers.

You have the right to expect protection of confidentiality in your care.

You have the right to be an important part of the treatment team.

You have the right to request to be notified in advance of all charges for services received.

You have the additional right as outlined in the Mental Health Code of Illinois

Patient Responsibilities

You may be requested to sign a form stating that you are willing to receive services through Taking Control.

Appointments

You have the responsibility to attend your scheduled appointments or to give appropriate notice if you are unable to attend. We understand that emergencies may arise that may interfere with your scheduled appointment. There are no-show and late cancellation policies for the agency, which are discussed in this information packet.

Medication

Please notify your psychiatrist of adverse effects (bad side effects) of your medication. *Compliance with medications:* Please take your medication as prescribed by your psychiatrist. If you desire to stop taking medicine or adjust your dose, discuss it with your psychiatrist first. Do not share your medications with others. Make sure that your medications are kept in a safe and secure place, away from children and others. Watch your medication supply to ensure that you do not run out of medicine.

Co-Payment

You have the responsibility to make your co-payment at the time of service. If this is a problem, please discuss this with your therapist. Your therapist may need to discuss alternative financial arrangement requests with the Business Office. You may be asked to sign a form acknowledging your financial responsibility.

Child Supervision

It is the patient or family's responsibility to provide adequate supervision for any children who are under the age of ten who may be in the waiting room. We cannot provide childcare or supervision. If the appointment is split between parent and young child, you should bring someone with you to supervise your child in the waiting room. Please be considerate of others in the waiting room.

Respect of Property

Please show respect to the therapist and to their property and the property of Taking Control. Do not bring in potentially dangerous/illegal materials. You may be held financially and legally responsible for property damage caused by you or others you are responsible for.

Procedures

Your therapy record is private and you have the right to a copy of any documented aspects of your treatment. A request for any specific documentation may be made in writing and will be accommodated as soon as reasonably possible.

Confidentiality

General Release of Information: In most cases, information is released only to those you designate in writing or who are so designated by your legal guardian. Information may also be given to your primary care physician to coordinate treatment. Consent is required in writing if the physician is not part of Taking Control.

Emergency Situations: Confidentiality may be waived in circumstances of danger when psychiatric symptoms are of such severity that there may be an imminent risk of 1) suicidal action, 2) homicidal action, or 3) inability to care for basic needs, leading to some risk of danger. Confidentiality also may be waived in cases of child/elder abuse. These waivers of confidentiality are performed in accordance with state law.

Legal Situations: As a rule, records are not released in legal situations unless written consent is given by the patient or by a parent or guardian. Files are written discretely, often with minimal detail in the event that records are released. Records cannot be written in such a way as to distort the diagnosis or the scope of the treatment. In the case of court order or subpoena, our attorney and the patient/guardian are consulted prior to any record release. Records may not be “discoverable” (for example, in divorce or custody cases).

Release of records is always done in accordance with the law and the patient’s best interest.

Patient Right to View Records: You have an absolute right to inspect and copy your records, which remain at Taking Control. The therapist may recommend that you view the record during an appointment so that the file can be interpreted to you and questions can be answered immediately. Any raw psychological test data may not be disclosed, by law, to any individual other than a registered psychologist.

Patient Record Transfers: You have the right to transfer copies of treatment records to a subsequent mental health professional upon the signing of a written consent form.

No-Show/Late Cancellation Policy

Emergencies may occur and other circumstances may arise, which make it difficult to attend scheduled appointments. We request that you notify us at the earliest possible time if you must miss an appointment. It may be impossible to fill the late cancellations and we cannot fill no-show appointments.

Your appointment is your time -- the office does not “double-book.” Full charge may be assessed for late cancellations made less than 24 hours in advance, and no-shows, based on the reason. Your insurance carrier or managed care plan may require that you take on full financial responsibility for this.

Late Arrivals: If you arrive late and your appointment time has passed, all efforts will be made to accommodate you at a different time. If the total time for your appointment has not elapsed, we will attempt to conduct all work possible during the remainder of your scheduled time.

The therapist, at his or her discretion and based on the appointment schedule, may be able to extend the appointment past its normal ending time. If the schedule does not permit this and further treatment time is necessary, we will make every effort to schedule another appointment as soon as possible.

A CONSENT FORM, WHICH STATES COMPREHENSION AND ACCEPTANCE TO THIS POLICY, WILL BE GIVEN TO ALL CLIENTS TO SIGN.

Self-Pay Charges

As stated above, you are responsible for payment of HMO/PPO/POS co-payments at the time of service. Please present your co-payment to your therapist at the beginning of your session. You will receive receipts for these payments. Please save them to verify payment.

The Evidence of Coverage booklet from your insurance company, which describes your payment benefits, should detail co-payment levels. Your therapist can help you if you have questions about co-payments. You have financial responsibilities to pay for fees not covered by your insurance plan. You may be asked to sign a consent form to verify that you understand that certain services (for example, certain types of psychological testing) are your financial responsibility.

It is the client’s responsibility to contact their insurance company if there is a question whether a specific form of therapy is covered for payment.

Please refer to the Financial Policy on page 12 for “No-show and late cancellation” policy.

A replacement cost will be assessed for the loss of take-home testing materials or borrowed reading materials, theft, or destruction of property. These types of actions may also result in legal proceedings or termination of services,

based on the circumstances of the situation.

Changing Therapist

Occasionally, a patient may feel that it is the best interest of their treatment to change providers. If this happens, we suggest the following:

1. Discuss your concerns with the provider in an attempt to resolve the difficulty. Often, a face-to-face appointment may be more helpful than a discussion over the telephone. Please remember that the provider wants the treatment to work and is willing to discuss the reasons for the treatment approach and to try to address issues. Sometimes, pressure builds up when a patient gets deeper into issues, and a change of therapist at that time may mean the loss of valuable opportunity to work through those issues.
2. If this does not lead to a resolution, please request that your current provider arrange for a second-opinion evaluation by another provider. Your current therapist, the new provider, and you can discuss how to make the transfer to services as smooth as possible.

Communication of Concerns

If you have any concerns that you wish to discuss about the department policies or your treatment, please be aware that there are staff members who are interested in hearing them and helping you. Please talk to your therapist.

We hope this information helps you understand your rights and responsibilities as well as the policies and procedures of Taking Control. We welcome your comments and suggestions and hope that your time with us allows you to meet your treatment goals.

TAKING CONTROL

NOTICE OF PRIVACY PRACTICES

Effective date: 4/2/15

This notice describes how private health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

If you have any questions, please contact the Privacy Officer at the address/phone number at the end of this notice. All written requests or appeals should be submitted to the Privacy Officer.

Who will follow this notice?

Taking Control provides mental health counseling services to our clients through the services of mental health professionals. The information privacy practices in this notice will be followed by:

All mental health care professionals who treat you
All of our employees, staff, and volunteers, with whom we may share information.

Our Pledge to You

We understand that health information about you is personal, and are committed to protecting the privacy of your health information. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by our facility staff, or those received from other health care providers. The law requires us to:

Keep health information about you in a private and secure location.
Give you this notice of our legal duties and privacy practices with respect to your health information.
Follow the terms of the notice currently in effect.

Changes in this Notice

We may change our privacy policies to this notice at any time. Changes will apply to health information we already hold, as well as, new information held after the changes occur. Before a policy change affecting the privacy of your health information, we will change this notice and post the new notice in waiting areas and staff offices. You can receive a copy of the notice at any time. You will be offered a copy of the current notice each time you register.

How we may use and disclose health information about you

We may use and disclose health information about you for treatment (such as sending health information about you to a specialist) as part of a treatment (such as sending billing information to your insurance company or to Medicaid) and to support our health care operations (such as comparing patient data to improve treatment methods).

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out health information for public health purposes (such as reporting births and deaths, preventing/controlling disease, injury, or disability), abuse or neglect reporting, health oversight audits or inspections, research studies, coroner/medical examiner reviews, worker's compensation purposes, governmental functions (such as protection of public officials or reporting to various branches of the armed services) and emergencies.

We may also disclose health information when required by law, and for law enforcement purposes, such as in response to request from law enforcement in specific circumstances or in response to valid judicial or administrative orders, if you are a member of the armed forces or foreign military personnel or if you are an inmate or under the custody of a law enforcement official.

We may also contact you for appointment reminders or aftercare follow-up to tell you about or recommend possible treatment options, alternatives, health-related benefits or services that may be of interest to you, unless you tell us that you do not want to be contacted to support fundraising efforts.

We may disclose your health information to our business associates, each of whom has entered into a written contract with us regarding the privacy of your health information.

Other uses of health information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing health information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing. However, we cannot take back any disclosures already made with your permission, and must keep records for your care.

Your rights regarding health information about you

In most cases, you have the right to look at or get a copy of health information that we use to make decisions about your care when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing, or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct or amend the records by submitting a request in writing that provided for your reason for requesting the correction/amendment. We could deny your request to correct or amend a record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information that have you right to look at; or if we determine that record is accurate and complete. You may appeal, in writing, a decision by us not to correct or amend your record.

You have the right to a list of certain instances where we have disclosed health information about you when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after May 1, 2004. You may receive the list in paper. The first disclosure list requested in a 12-month period is free. Other requests within the same 12-month period will be charged according to our cost of producing the list. We will inform you of the fee before you incur any costs.

You have the right to request that health information about you be communicated to you in a confidential manner, such as sending mail to an address other than that of your home by notifying us in writing of the specific way or location for us to communicate with you. We will not ask you the reason for your request, and will accommodate all reasonable requests.

You may request, in writing, a limit on the health information we use or disclose about you for treatment, payment or healthcare operations; you may request that we limit the health information disclosed about you to someone who is involved with your care, payment for your care, except when specifically authorized by you when required, or in an emergency. In your request, you must state: 1) What information you want to limit, 2) whether you want to limit our use, disclosure or both, and 3) to whom you want to limit the information (for example, disclosures only to your spouse). We will consider your request but are not legally required to accept it. We will inform you of our decision on your request.

Acknowledgement of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices and Rights for Taking Control. I understand that I may contact the designated Privacy Officer at Taking Control if I feel that my privacy has been violated.

If filling out this form for a minor, list their name: _____

Client or Parent/Guardian Signature: _____ Date: _____

TAKING CONTROL
CONSENT FOR DISCLOSURE OF CONFIDENTIAL CLIENT INFORMATION

I, _____ hereby request **Taking Control Counseling** to disclose the contents of my confidential case records, and/or communications, in accordance with the terms and conditions herein set forth, to: _____ . The purpose or need for this disclosure is:

_____.

The extent, type, and nature of the information or records to be disclosed is (circle one):

Type of Information	
Duration of involvement in program	Yes/No
Summary of treatment participation	Yes/No
Medical History	Yes/No
Social History	Yes/No
Other (specify):	

I understand that this consent will automatically expire on _____

I understand that it is my right to revoke this consent for the release of this information at any time, in writing.

I consent to allow release of only the information specified on this consent form.

I understand that once received, the information cannot again be given to any other agent or person by the recipient without my written consent.

I understand that the information released may only be used for the purpose itemized on this form.

I understand that it is my right to inspect and copy the information that is to be disclosed.

I understand that should I refuse to disclose the information itemized above the consequences of such refusal (if any) will be _____

_____.

 Client Signature (if 12 yrs of age or older)

 Date

 Staff Member/Witness

 Date

 Parent/Guardian Signature

 Date

 Staff Counselor

 Date



Finding Solutions that work.

Financial Policy

I, Card Holder Name: _____ authorize Taking Control and therapists/independent contractors within Taking Control's office to securely keep on file and charge my card:

Card Number: _____

Expiration Date: _____

Security Code on Back: _____

Billing Zip Code: _____

My Card will be charged, including manually, for the following:

- Balance of charges not paid by client within 90 days for previously rendered counseling services.
 Charged for 50% of session fee for no cancellation prior to 24 hours.

____ (initial) I understand this form is valid unless I cancel or change the terms of authorization through written notice.

____ (initial) I understand that if my card on file shall expire and charges stated above accumulate a balance, therapeutic services may be placed on hold until a valid card is updated on file or until balances are paid.

I also understand that I will be charged for 50% of the full session fee (not limited to a copayment) for missed appointments canceled within 24 hours as explained in fee agreement.

I understand and agree to the terms of the Financial Policy.

Signature: _____ Date: _____