REVISIONS COUNSELING SERVICES LLC
SERVICE AGREEMENT / INTAKE / CONSENT FOR TREATMENT

Date: _____/_____/_____

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.

Notice of Privacy Practices
Effective date: May 21, 2019

Revisions Counseling Services 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.

The documents in this New Client Packet are explained below. Please GIVE THIS NEW CLIENT PACKET TO YOUR THERAPIST AT YOUR 1ST APPOINTMENT after you have read and signed all the appropriate documents in it. NOTE: If you are typing your information into this form, please note that all signatures must be handwritten. This New Client Packet includes the following documents:

Client Information Form: Please complete this in its entirety so we will have all the necessary information to assist with your insurance billing. We also request that we be able to make a copy of your insurance card.

REVISONS COUNSELING SERVICES LLC, is committed to strengthening and healing families from all levels of society through clinical service, education, and research. REVISONS COUNSELING offers a wide range of high-quality behavioral health care through our staff practice and sliding-fee-scale agency for those without coverage and/or there is a financial loss and need. Each location's hours are by appointment only.

Please be aware that children under 12 years old cannot be left alone in waiting rooms. If your children are not participating in your session, please plan for their care.

Uses and disclosures of your health information for the purposes of providing services:
Providing treatment services, collecting payment(s), 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.
_____ _____ (Client initials)

SERVICES: Services may include, but are not limited to: family, couple, individual and group therapy, as well as psychological testing, school consultation and other diagnostic services as recommended by the clinician
_____ _____ (Client initials)

Services may also include the participation of parents/guardians and other significant family members, when appropriate. Family Institute clinicians working with multiple members of the family in different modalities (e.g., individual, couple or family therapy) will, with your consent, consult with each other and share information in order to provide effective and coordinated care. Information provided by those participating in couple or family therapy is shared among members participating in that type of treatment. Within our clinic, treatment length will be evaluated based on progress towards mutually agreed upon goals for therapy.
_____ _____ (Client initials)

Court-Ordered Services: Court-ordered visitation, mediation and 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-ordered 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.
_____ (Client initial)

ELECTRONICALLY FACILIATED PSYCHOTHERAPY: Your clinician may provide one or more forms of electronically facilitated therapy, including teletherapy or a therapeutically oriented email exchange. At this time, insurance companies do not provide coverage for these services and clients are expected to pay the clinician's regular fee. Before electronically mediated psychotherapy can be initiated, your clinician will conduct an in-person assessment and review limits, if any, to ensure your confidentiality.
_____ _____ (Client initials)

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. _____ (Client Initial)

FEES: Clients are expected to pay all fees and co-payments at the time of service. If clients become delinquent in payment of fees, Revisions counseling Services LLC, may suspend or terminate treatment. Unpaid bills are turned over to collection after an appropriate attempt to collect.
_____ _____ (Client initials)

Fees for services (non-direct) outside the scope of normal therapy are billable separately at the clinician's regular fee. These may include school visits, court appearances, phone consultations, writing or reviewing letters, reports, etc. These charges are not typically reimbursed by insurance. It is recommended that you discuss with your therapist his/her approach to handling such charges, and the type of non-direct services that are likely to occur during the course of your work together. Revisions Counseling Services LLC would like all clients to provide credit/debit card information at the time of registration. This information will facilitate the settlement of any balances that may be your responsibility
_____ _____ (Client initials)

Regarding Use of Insurance: Clients are responsible for contacting their insurance companies and understanding their insurance benefits prior to the first session.
Not all at Clinical Clinicians at Revisions Counseling Services LLC, are providers for all health insurance plans. Please be aware that if your mental health benefits are covered through another carrier, such as United Behavioral Health, Magellan, ComPsych or Value Options, etc., Revisions Counseling Services LLC, is NOT considered in-network, and BCBS PPO rates do not apply. There may be additional client responsibility such co-insurance, deductible or other non-covered services that will be due once the claim adjudication is complete.
Charges for services not covered by insurance, e.g., co-payments, deductibles, uncovered and ineligible services and all charges for services provided over the maximum allowable benefit for the year, are the client's responsibility. We encourage clients to contact member services regarding their benefits prior to the first session so they are aware of what may or may not be covered._____ _____ **(initial)**

Self-Pay: All Clients at Revisions Counseling Services LLC, are asked to provide credit/debit card information at the time of registration. This information will facilitate the settlement of any balances that may be your responsibility.
_____ _____ **(initial)**

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.
_____ (Client Initial)

Financial Responsibility Account balances that remain unpaid for more than 90 days may be forwarded to a collection agency. The client will bear the full cost of collection activity.
_____ **(initial)**

Fees & services I have received a copy of the fee schedule. _____ **(initial)**

CONTACTING CLINICIANS: Clients may leave confidential messages for their clinicians on the voice mail system of Revisions Counseling Services LLC at any time. Revisions Counseling Services LLC does not provide after hours or emergency services. For after hour communication with your clinician, please leave an email or voicemail message. In case of emergencies, please call 9-1-1 or go to the emergency room.
_____ _____ **(initial)**

APPOINTMENT CANCELLATION POLICY: Charges apply for psychotherapy appointments canceled (or changed) with less than 24 hours' notice. Extenuating circumstances are considered when appropriate. _____ _____ **(initial)**

COMMUNICATIONS: Periodically, Revision Counseling Services LLC sends news and updates on its various programs and activities. You will receive eNewsletters, helpful Tips of the Month, donor stewardship materials and invitations from Revision Counseling Services LLC. If at any time you wish to stop receiving these communications, please send written communication to the Privacy Officer of Revision Counseling Services LLC 190 Lily Lane Bolingbrook IL.
_____ _____ **(initial)**

FOID MENTAL HEALTH REPORTING REQUIREMENT: As per Illinois Firearm Concealed Carry Act, all physicians, clinical psychologists, and qualified examiners are required
_____ **(initial)**

Court-Ordered Services: Court-ordered visitation, mediation and 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-ordered 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.
_____ _____ **(initial)**

Please be advised that participation in court-ordered 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 to notify the Department of Human Services (DHS) within 24 hours of determining a person to be a Clear and Present Danger to themselves or others, Developmentally Disabled or Intellectually Disabled, regardless of the provider's practice, the person's age, or any other diagnosis of this person.
_____ _____ (Client initials)

NOTICY OF PRIVACY PRACTICES: By signing, you acknowledge that you have received the Notice of Privacy Practices of Revision Counseling Services LLC. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.
_____ _____ (Client initials)

MANDATED REPORTING: 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. All clinical service providers at Revision Counseling Services LLC are mandated reporters. 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; This obligates them to comply with the Abused and Neglected Child Report Act that states that any worker "having reasonable cause to believe a child known to them in their professional capacity may be an abused or neglected child shall immediately report or cause a report to be made to the Department." All mandated reporters in the State of Illinois are also required to report suspected or reported "abuse, neglect or financial exploitation" of individuals over the age of 60 years to the Department of Aging. 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-ordered services are typically limited in their protection of confidentiality.
_____ _____ (Client initial)

Cancellations and Communications If you need to cancel or reschedule an appointment, please give 24 business hours advance notice; otherwise, you will be billed at the hourly rate. Phone calls over 5 minutes will be charged a pro-rated fee. I understand the cancellations and communications policies.

Client Consent to Terms of Agreement: I/We, the undersigned, understand this Service Agreement and apply for services at Revision Counseling Services LLC in accordance with this agreement. A signature is required from the parent(s) or guardian(s) who have legal responsibility for medical decisions for children in treatment. I/We understand that I/we have the right to revoke this consent at any time. This revocation must be in writing to Revision Counseling Services LLC.

We sincerely appreciate your cooperation and at any time you have any questions regarding fees, balances, or payments, please feel free to ask. You may have a copy of these forms if requested.

Participants in Treatment:
Printed Name _____
Signature _____
Email Address _____

Printed Name _____
Signature _____
Email Address _____

Guarantor

As guarantor, I am accepting financial responsibility for services received at Revision Counseling Services LLC. I am also responsible for notifying Revision Counseling Services LLC. Billing Department if my status as guarantor has changed or if financial responsibility for treatment is a shared responsibility.
If I do not inform Revision Counseling Services LLC. Billing Department, I remain liable for the charges. _____ (Guarantor's Initials)

Guarantor's Name _____
Signature _____
Date _____
Email Address _____

Revision Counseling Services LLC. Clinician Name _____
Signature _____
Date _____

Insurance Information

Client Name:_____
DOB:_____/_____/_____
Social Security Number: _____

Insured's Information
Name:_____ DOB:_____/_____/_____

Social Security Number:_____ Phone:(____)_____-_____
Employer:_____

Insurance Carrier:_____
Member ID:_____ Group ID:_____

Insurance Carrier:_____
Member ID:_____ Group ID:_____

Claim Address (back of card): _____
_____

I authorize Revisions Counseling Services LLC to release any information necessary in processing this claim. Additionally, I authorize payment of medical benefits to this provider for services rendered.

Signature:_____ Date: _____/_____/_____

Thank you for choosing **Revisions Counseling Services LLC**, as your service provider.

REVISIONS COUNSELING SERVICES LLC
SERVICE AGREEMENT / INTAKE / CONSENT FOR TREATMENT

Your first appointment will take approximately 60 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal laws, and your rights. If you have other questions or concerns, please ask and we will do our best to provide you with all the information you may need. I, Regina Thomas is a LCPC have earned a Bachelor of Science Degree in Clinical Mental Health Counseling from Walden University. I am licensed by the State of Illinois as a Licensed Clinical Professional Counselor. I have over 10 years of clinical experience using individual and family therapy. I use cognitive-behavioral therapy for most conditions including, but not limited to, grief, addictions, anxiety, depression, and PTSD; although, other treatment approaches may be used depending on the person or condition. My associates have also earned their Masters-Degree and are licensed by the State of Illinois. Individual, marital, family, mediation, and coaching sessions etc., are 45-50 minutes. Play therapy and young children's sessions are 30-40 minutes. Treatment practices, philosophy and plan limitations and risks will be discussed with you at your first appointment.

Confidentiality and Emergency Situations:
All information regarding clients is considered confidential and will not be given to anyone outside of Revisions Counseling Services LLC, without your written consent. Exception are listed in our Notice of Privacy Practices. In the event of a request for the transfer of records to another party, the records will be forward directly to that party only upon receipt of your written request.

I give my consent to (treating therapist) _____ to provide evaluations and treatment that we may mutually determine to be appropriate. I am participating in my treatment voluntary 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.
_____ (initial if applicable) I understand the above-named therapist is receiving weekly supervision from Revisions Counseling Services LLC licensed therapist.

I _____ have been presented with a copy of Revisions Counseling Services LLC, notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the Notice. Please Check one:
_____. I have read and received a copy of the Noticed of the Practices.

_____. I decline receiving a copy of the Noticed of Privacy Practices and am aware that this Notice can be view online at Revisions Counseling LLC website under Form and Documents.

Signature:_____ Date:_____/_____/_____
Signature:_____ Date:_____/_____/_____
(Client age 12 or older)
Signature:_____ Date:_____/_____/_____

Confidentially continued.

Your verbal communication and clinical records are strictly-confidential except for:
a) information shared to the client(s) 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-ordered services;
h) when required by law (such as 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. Revisions Counseling Services LLC 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:_____/_____/____

Client Contact Options

I understand that email and text reminders are a courtesy and it is ultimately my responsibility as a client to remember my appointments. _____ (Client Initial)

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? _____

____ I hereby give Revisions Counseling Services LLC, permission to send email reminders regarding my appointment dates and times. I understand that email is not a confidential mode of communication.

1. Email Address.
_____
2. Email Address_____

Or
____ I do not want to receive appointment reminders through email.

I would also like to receive Revisions Counseling Services LLC, e Newsletter (emailed articles by therapists 6x year)
_____Yes _____No
AND/OR_____ I hereby give Revisions Counseling Services LLC, permission to send text reminders regarding my appointment dates and times. I understand that texting is not a confidential mode of communication.
Or
_____ I do not want to receive appointment reminders through text.

Parent/Guardian Signature _____
Date _____
Client (age 12 or over) Signature _____
Date _____

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: (____)_____-_____ Fax: (____)_____-_____
Address:_____

Fee Schedule & Financial Issues

Initial Consultation $275
Individual, Family, & Adult Therapy/Mediation/Consulting/Coaching-Sessions $140-$240 (Based on Therapist)
Child Adolescent Sessions $120-$140
(Based on Therapist)

Fees for Services/Self Pay: No health insurance is accepted - Revisions Counseling Services LLC, your fee will be $(_____)(_____ _____ (Client initials)

FINANCIAL/INSURANCE ISSUES: As a courtesy, our staff will bill your insurance company, responsible party, or third-party payer for you, if you wish. We ask that at each session you pay your copay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00, we will need to ask that you pay for services when rendered. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed. We ask that every client authorize payment of medical benefits directly to Regina Thomas, LCPC.
NSF Checks There will be a $35.00 charge for any returned check.
Telephone Calls: Telephone calls lasting more than 5 minutes will be billed to the client. Clients will be billed at the pro-rated charge of 1.00 for each additional minute for the duration of the telephone call.
Completion of Forms/Letters Completion of Forms will be billed at $25.00 up to 2 pages. Additional pages will be billed at $10.00 per page. Request for letters will be billed at $25.00. This fee is not covered by insurance and will be billed directly to the client. Please allow up to 10 business days for the completion of requested
Letters/forms. Record Requests In order to fulfill a records request, a signed Release of Information form must be completed and submitted to our office. A fee of $25.00 will be applied to all Record Requests. Please allow 10 business days from the receipt of the ROI for the request to be completed.
Cancellation/No Show Policy It is the responsibility of the client to notify the office 24 hours in advance when cancelling an appointment. If you need to cancel or reschedule an appointment, please give 24 business hours advanced notice; otherwise, you will be billed at the hourly rate. In addition, the client has will incur a $50.00 late cancellation/no show fee. This fee is not covered by insurance and will be billed directly to the client.

If you need to cancel or reschedule an appointment, please give 24 business hours advanced notice; otherwise, you will be billed at the hourly rate. We sincerely appreciate your cooperation and 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:_____/_____/_____

TREATMENT

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: (_____) _____-_____

(Please check one)
☐ You may inform my physician(s) ☐ I decline to inform my physician(s)
Physician Name:
_____
Clinic Name:
_____
Address: _____
Phone: (_____)_____-_____

Signature:_____ Date:_____/_____/_____

Request to Release Information to Primary Care Physician (PCP) Communication

Request to Release Information to Primary Care Physician (PCP) Communication between your therapist and your PCP 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. Please indicate your wishes below. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent shall expire one (1) year from the date of signature, unless another date is specified.

Signature:_____ Date:_____/_____/_____

Please Check One:
__ I do not have a Primary Care Physician.
__ I do not authorize Revisions Counseling Services LLC, to release information to my Primary Care Physician.
__ I request that Revisions Counseling Services LLC, release mental health/substance abuse information to my Primary Care Physician.
Complete information must be provided to contact your PCP:
Primary Care Physician Name:_____
Phone: _____
Note: Please sign below regardless of which box you checked above.

Client (age 12 or over) Signature _____ Date _____
Parent/Guardian Signature_____ 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.):
_____
_____
_____
_____
_____
_____

Consent for Treatment of Children or Adolescents

Separate forms are required for each child

I/We consent that _____ (DOB:_____/_____/_____) may be treated as a patient by Revisions Counseling Services LLC.

We ask for your cooperation to provide the timeliest 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 Revisions Counseling Services LLC. I understand that a revocation is not valid to the extent that Revisions Counseling Services LLC, has acted in reliance on such authorization.
_____ (initial)

Client Signature (12 years or older):_____
Date:_____/_____/_____

Witness Signature:_____
Date:_____/_____/_____

Parent 1 Signature:_____
Date:_____/_____/_____
Relationship: _____

Parent 2 Signature:_____
Date:_____/_____/_____
Relationship: _____

SYMPTOM CHECKLIST A

(to be filled out by Client)
Date_____
Please Print)
Client Last Name_____First Name_____
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 Checking the appropriate answer to each question.

Symptoms

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

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

(to be filled out by Parent/Guardian if client is minor or by Significant Other/Spouse if couple)

Date_____
(Please Print)
Client Last Name_____First Name_____
Statement of problem(s) for which you/your child now seek counseling:
_____
_____
_____
_____
_____
_____

Please rate the degree to which you/your child have been experiencing the following problems during the PAST MONTH by Checking the appropriate answer to each question.

Symptoms

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

When did the symptoms first begin? _____(date)
Have you ever been treated for these symptoms before? Yes _____No_____
If yes, when? _____(date)

AUTHORIZATION TO RELEASE PROTECTED INFORMATION FROM YOUR CLINICAL RECORD TO THE PERSON YOU DESIGNATE

I authorize_____(Facility/Therapist's Name) to release (specific nature of information to be released):
_____ about (Recipient's Name): _____ to (Receiving Agency/Person's Name and Address):
_____
_____
The information requested above is being released for the purpose of
_____
_____
This consent is valid until: _____/_____/_____
Month Day Year The statues that govern this Authorization include but are not limited to: Mental Health and Developmental Disabilities Confidentiality Act (740ILCS110), 735ILCS5/8-2001 (inspection and copying of hospital records), and any relevant confidentially code of any state, and the Employee Personnel Records Act, 820 ILCS 40/0.01

I understand that I have the right to copy and inspect (other than Psychotherapy Notes as defined in 45 CFR @ 164.501) the information being disclosed. I have the right to revoke this authorization, in writing, at any time by sending such written notification to my provider's office. However, my revocation will not be effective to the extent that my provider has acted. 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 my mental health practitioner generally may not condition mental health services upon my signing an authorization unless the mental health services are provided to me for the purpose of creating health information for a third party. It has been explained to me that if I refuse to consent to this Release of Information specified above, the following are the consequences (or indicate "none"):_____
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 and the legal basis on which consent is given for the
recipient:_____
X_____
Date: _____ (Witness)

Notice to Receiving Agency/Facility/Person: Under the provision of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, (740 ILCS 110/1 et.seq.) you may not redisclose any of this information unless the person who consented to this disclosure specifically consents to such redisclosure.
Under Federal Act of July 1, 1975, Confidentiality of Alcohol and Drug Abuse Patient Records, no such records, nor information from such records may be further disclosed without specific authorizations for such redisclosure.

Financial Responsibility

Financial Responsibility Account balances that remain unpaid for more than 90 days may be forwarded to a collection agency. The client will bear the full cost of collection activity. We accept cash, checks, VISA, MASTERCARD, AMERICAN EXPRESS, and DISCOVER.

I have read, and I understand the above policies and agree to abide by them.
Financially Responsible Party _____
Relationship to Client _____
Address_____City_____
__State _____ Zip _____
Phone ≤H ≤W ≤C _____ Alternate Phone _____
SS # _____ DOB _____

Signature _____
Date _____
Client Name (PLEASE PRINT) _____