Oak Brook
Counseling & Wellness

Oak Brook Counseling & Wellness
1010 Jorie Blvd. Suites 112 & 246, Oak Brook IL 60523
630.710.5729 | sgosmirelcpc@hotmail.com

Registration

Date:_____ Client Name:_____ Date of Birth_____

Phone Numbers: Cell:_____ Work: _____Home:_____

Parent's Name, if applicable (if client is a minor) _____Parent's Phone Number _____

Contacts and Releases

May we leave a message on your voicemail? yes or no

Address_____City _____ State_____ Zip_____

Marital Status:_____

Often times email and or text messaging is used to confirm or make appointments. This form of communication is sometimes unsecure. Please sign if you give permission to receive text and/or email.

X_____ Email address_____

Emergency contact:_____ Phone number _____

Sign to give permission to release information to above-named person in case of an emergency: _____

Would you like us to contact your primary care or another physician? Yes__ No__

If yes, please provide physician's name and phone number: _____

Sign to give permission to release information to above-named physician: _____

Insurance Information

Insurance Name _____ Insurance ID #_____ Policy #_____

Name of primary insured person_____ Date of birth_____

I, _____Date_____, give my consent for Oak Brook Counseling & Wellness providers to exchange information with my insurance company for authorization and reimbursement. I also request of insurance benefits to myself or to Oak Brook Counseling & Wellness.

X_____Date_____

How did you hear about Oak Brook Counseling & Wellness? _____

Psychotherapist-Client Service Agreement (You will be given a copy of this document for your records)

Welcome to Oak Brook Counseling & Wellness. This document contains important information about our professional services & business policies.

The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you may have. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular issues you bring forward. There are many different methods I may use to assist with issues that you hope to address. My style holistic and includes working with the mind and body connection that includes meditation and mindfulness skill building.

Also, if Sabrina Gosmire, LCPC, CADC, or Candida Jacoby, LCSW are your clinicians, they are trained in the use of clinical hypnosis which is an additional and/or optional tool available to us in the counseling process.

Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Beginning therapy: Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. We may decide, after one or more sessions, that your needs would best be met by another therapist or practice and in that case we will provide referrals for your continued care. If you have questions about procedures, you should discuss them with me whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Termination of therapy: We respect the right of all clients to terminate therapy when they are ready. Most clients feel better about terminating therapy when they discuss it openly with their therapist before moving on. This allows the client and therapist to review the clients' progress on therapeutic goals and discuss future directions on the path toward wellness.

MEETINGS

We normally conduct an evaluation that will last from 1 to 3 sessions. During this time, your therapist will decide if he or she is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 53-minute session (one appointment hour of 53 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

Cancelation policy

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 48 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for sessions cancelled late. In cases of late cancellation or failure to appear for appointments, you will be charged the full contracted or otherwise agreed upon rate.

PROFESSIONAL FEES

The first session fee is $175.00. Each additional session is $160.00. In addition to weekly appointments, we may charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of us.

Contacting Us

We can be reached by telephone at 630.710.5729. If we don't answer, you can leave a message. (1). We check messages frequently during weekdays and usually respond within 48 hours. Messages left on the weekend will be responded to on Monday. (2). **If you cannot wait for us to return your call, contact your psychiatrist, family physician, or go to the nearest emergency room. (3)** If your therapist will be unavailable for an extended time, coverage will be provided by another qualified psychotherapist.

Electronic Communication

In order to maintain clarity regarding our use of electronic modes of communication during your treatment, we have prepared the following policy. This is because the use of various types of electronic communications is common in our society, and many individuals believe this is the preferred method of communication with others, whether their relationships are social or professional. Many of these common modes of communication, however, put your privacy at risk and can be inconsistent with the law and with the standards of my profession. Consequently, this policy has been prepared to assure the security and confidentiality of your treatment and to assure that it is consistent with ethics and the law. Clients frequently find it convenient to communicate with their therapist via text message or email. Please restrict your use of these forms of communication to logistical matters regarding scheduling of appointments or billing issues. It is important to be aware that electronic communications are vulnerable to unauthorized access due to the fact that servers have unlimited and direct access to all emails that pass through them. Do not use these formats to convey sensitive personal information, as confidentiality cannot be guaranteed. If you communicate confidential or private information via email, we will assume you have made an informed decision to take the risk that such communication may be intercepted. Emails also may not be deliverable or received. Do not use email or texting when you have an emergency.

Email Communications

We use email communication and text messaging only with your permission & only for administrative purposes unless we have made another agreement. That means that email exchanges & text messages with the office should be limited to things like setting & changing appointments, billing matters & other related issues. Please do not email us about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter with us, please feel free to call so we can discuss issues over the phone or wait so we can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of

communication. We also use the HIPAA-compliant OhMD phone app to communicate securely with clients, but strictly for non-emergency uses. Should your clinician wish to use this, they will introduce it to you in session.

Social Media
We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

If you have an online presence, there is a possibility that you may encounter you clinician by accident. If that occurs, please discuss it with your clinician during your scheduled time together. We believe that any communications with clients online have a high potential to compromise the professional relationship. In addition, please do not try to contact us in this way.

Websites
Oak Brook Counseling & Wellness (OBCW) has a website that you are free to access. It is used for professional reasons to provide information to others about OBCW. You are welcome to access and review the information and, if you have questions about it, we should discuss this during your therapy sessions.

Web Searches
We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about us in this way. In this day and age there is an incredible amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be inaccurate or unknown. If you encounter any information about us through web searches, or in any other fashion for that matter, please discuss this with us during our time together so that we can deal with it and its potential impact on your treatment.

Recently it has become fashionable for clients to review their healthcare provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of me or any professional with whom you are working, please share it with your clinician so we can discuss it and its potential impact on your therapy. Please do not rate the work of your clinician while you are in treatment together on any of these websites. This is because it has a significant potential to damage our ability to work together.

Electronic File: Identifying information and clinical notes are kept in a secure, confidential, HIPAA compliant electronic file. The program used is TherapyNotes. Billing to insurance companies is sent through TherapyNotes.

Limits of Confidentiality
The law protects the privacy of all communications between a client and a psychotherapist. In most situations, we can release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA and/or Illinois law. However, in the following situations, no authorization is required:

We may occasionally find it helpful to consult with other health and mental health professionals about a case. During a consultation, we will not reveal your name or other identifying information. The other professionals are also legally bound to keep the information confidential. As a general rule, we will not tell you about these consultations unless we feel that it is important to our work together.

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychotherapist-client privilege law. We cannot disclose any information without a court order or your written authorization. If you are involved in or contemplation litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

If a government agency is requesting information for health oversight activities, we may be required to provide it for them.

If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

If you file a worker's compensation claim, and we are rendering treatment or services in accordance with the provisions of Illinois worker's compensation law, we must, upon appropriate request, provide a copy of your record to your employer or his/her appropriate designee.

There are some situations in which we are legally obligated to take action that we believe is necessary to attempt to protect others from harm. These situations would compromise the following:

Child or Elder Abuse: If we have reason to believe that a child or an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that we file a report with the agency designated to receive such reports. Once such a report is filed, we may be required to provide additional information.

Threat to harm others: If you have a specific threat of violence against another or if we believe that you pose a serious and foreseeable physical harm to another, we may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking your hospitalization.

Threat to harm yourself: If we believe that you present a serious and foreseeable harm to yourself (such as physical or mental injury or death to yourself), we are required to disclose information in order to take protective actions. These actions may include seeking your hospitalization or contacting family members or others who can assist in protecting you.

Animal abuse: If we have reason to believe that an animal in your care has been abused or neglected in the preceding 12 months, the law requires that we file a report with the agency designated to receive such reports. Once such a report is filed, we may be required to provide additional information.

If you present as a clear and present danger to yourself or others or are developmentally or intellectually disabled, we are mandated to report you to the Illinois Department of Human Services. See https://foid.dhs.illinois.gov/foidpublic/foid/.

These situations have rarely occurred in this practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action. In case of an emergency, your information may be shared. All efforts will be made to protect your confidentiality as it occurs.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. We are happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting an accounting of most disclosers of protected health information that you have neither consented to not authorized; determining the location to which protected information disclosures are sent; having any complaints that you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.
If you wish to have information shared with another party, you will be asked to sign a Release of information before sharing the information with the exception of the circumstances listed under limits of confidentiality.

DIVORCE/SEPARATIONAGREEMENT
Therapy services offer support to divorced or separated families, we are not able to make any statements to establish custody agreements, visitation schedules, or other family court matters.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. Please ask for the Sliding Scale Policy.

If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information released regarding a patient's treatment is his/her/their name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of the contracted rate with in-network insurance companies and full fees with out-of-network insurance companies. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

PROFESSIONAL RECORDS
The laws and standards of my profession require that we keep treatment records. Insurance companies can request information about you. Insurance companies cannot require your authorization as a condition of coverage, nor penalize you in any way for your refusal. You are entitled to receive a copy of your records, or we can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, we recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is our policy to request an agreement from parents that they agree to give up access to your records. If they agree, we will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else. In this case, we will notify them of my concern. We will also provide them with a summary of your treatment when it is complete. Before giving them any information, we will discuss the matter with you, if possible, and do our best to handle any objections you may have with what we are prepared to discuss.

Transfer of Care
In the event your therapist becomes disabled, dies, retires or becomes otherwise unable to provide counseling services, another therapist within the practice will provide counseling services, or services will be provided or arranged by Sharon Boris, LCSW, of Oak Brook, Illinois (phone 708.217.2726). Upon such an event, clients will be notified, arrangements will be made for continuation of counseling services, and client records will be maintained for seven years, after which time they will be destroyed.

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 therapists at Oak Brook Counseling & Wellness.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT & AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPPAA FORM DESCRIBED ABOVE.

_____ _____
CLIENT OR PARENT SIGNATURE DATE

Oak Brook Counseling & Wellness, INC.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

• Make sure that protected health information ("PHI") that identifies you is kept private. • Give you this notice of my legal duties and privacy practices with respect to health information. • Follow the terms of the notice that is currently in effect. • I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules and regulations allow health care providers who have direct treatment relationship with the client to use or disclose the client's PHI without the client's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your PHI for the treatment activities of any health care provider. This, too, can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, I would be permitted to use and disclose your PHI, which is otherwise confidential, to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers, and referrals of a client for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: (a) For my use in treating you; (b) For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy; (c) For my use in defending myself in legal proceedings instituted by you; (d) For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA; (e) Required by law and the use or disclosure is limited to the requirements of such law; (f) Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes; (g)Required by a coroner who is performing duties authorized by law; or (h) Required to help avert a serious threat to the health and safety of others. 2. Marketing Purposes. I will not use or disclose your PHI for marketing purposes. 3. Sale of PHI. As a psychotherapist, I will not sell your PHI.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION:

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. 2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety. 3. For health oversight activities, including audits and investigations. 4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so. 5. For law enforcement purposes, including reporting crimes occurring on my premises. 6. To coroners or medical examiners, when such individuals are performing duties authorized by law. 7. For research purposes, including studying and comparing the mental health of clients who received one form of therapy versus those who received another form of therapy for the same condition. 8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.

9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws. 10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT:

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations. Unless such disclosure is required by law (such as to comply with a subpoena), I may not make such disclosures without your express written consent.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care. 2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for in Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. 3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to reasonable requests. 4. The Right to See and Get Copies of Your PHI. Other than psychotherapy notes and personal notes, you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so. 5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last year unless you request a different timeframe. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request. 6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request. 7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on February 1, 2017
Acknowledgement of Receipt of Privacy Notice
Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received the Notice of Privacy Practices from Oak Brook Counseling & Wellness, Ltd.. This notice provides information about the ways in which we may use and disclose your protected health information. We encourage you to read it in full.

The Notice of Privacy Practices is subject to change. You may ask us at any time for a copy of the current notice, either in person or by contacting me at the number or addresses above.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____ _____
Printed Name Signature Date

If no signature is obtained above, describe the good faith efforts made to obtain the individual's acknowledgement and the reasons why it was not obtained.

_____

_____

Oak Brook Counseling & Wellness ~ 1010 Jorie Blvd. Suites 112 & 246 ~ Oak Brook, IL 60523

Financial Policies Agreement

Clients are responsible for payment of all services received. Clinical Fees are as follows:

Initial Evaluation (60-75 Minutes) $175.00 Individual Sessions (53 Minutes) $160.00
Reports $100.00
Cancellation Fee, less than 24 hours OR without Notice: Full contracted or otherwise agreed upon rate
Fees may be adjusted if using a sliding scale

Phone Consultations: Phone consultations are not reimbursable by insurance.
10-15 min = $75.00, 15-30 min = $125.00, 30 – 60 minutes $175.00
Sliding Scale Available for Patients without insurance.

Fees listed above are charged for missed appointments or no show cancelations with less than a 24 hour notice unless due to documented illness or emergency. A bill will be mailed or emailed directly to all clients who do not show up for or cancel an appointment. Two or more missed/no show appointments are grounds for termination from treatment.

Third Party Payers
Oak Brook Counseling & Wellness agrees to file insurance claims on behalf of the client. However, filing claims does not release client from responsibility for payment. Unpaid claims within 60 days of filing are billed to the client. If payment from the third party payer is received after the client has paid the balance, the client will be issued a refund.

Co-Payment, Co-Insurance and Deductible
Most third party payers require a co-payment or co-insurance fee from the client. This fee is due at the time of service. Many third party payers require that the client pay a set amount (deductible) prior to being able to access their benefits. Clients will be charged their deductible when applicable. This amount is estimated until the first claim is processed and received by Oak Brook Counseling & Wellness. Clients are notified of their benefits once information is gathered.

Credit Card
At clients first session, clients are asked to submit credit card information as an option for payment as well as for collecting unpaid fees. If there is an unpaid bill, after notification of balance, payment will be collected via credit card. This policy is designed to ensure payment of fees as well as maintaining the client's privacy by not involving a collection agency.

I, _____, give permission to Oak Brook Counseling & Wellness to process all unpaid balances on my credit card. I understand that this card will only be charged after I have received notice of outstanding balances which are more than 30 days outstanding.

I have read and agree to these policies.

Name _____ Date _____

_____
Last First Middle Initial

I authorize Oak Brook Counseling & Wellness to use Square or Ivy Pay which are credit card processing systems to charge my credit/debit card for collecting unpaid, deductibles, missed appointments and any balance not paid by my insurance company within 30 days of service.

Type of Card
☐ Visa ☐ MasterCard ☐ Discover ☐ Medical Savings/Expense

Credit Card Number_____-_____-_____-_____ CVV _____ Exp date _____

Cardholder's Billing Address

_____
Street City State Zip

Cardholder Signature

_____

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.
(For a child, mark any of these and then ask your therapist about the "Child Checklist of Characteristics.")

- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also 'Weight and diet issues')
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings
- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital issues
  - ❑Conflict ❑Distance/coldness ❑Infidelity/affairs ❑Remarriage ❑Different expectations
  - ❑Disappointments ❑ Parenting styles ❑Communication
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension

❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
❑ Oversensitivity to rejection
❑ Pain, chronic
❑ Panic or anxiety attacks
❑ Parenting, coparenting, child management, single parenthood
❑ Perfectionism
❑ Pessimism
❑ Procrastination, work inhibitions, laziness
❑ Relationship problems (with friends, with relatives, or at work)
❑ School problems (see also 'Career concerns')
❑ Self-centeredness
❑ Self-esteem
❑ Self-neglect, poor self-care
❑ Sexual issues (see also 'Abuse')
❑Dysfunctions ❑Conflicts ❑Desire differences ❑Preferences not matched by partner/s ❑Other
❑ Shyness, oversensitivity to criticism
❑ Sleep problems—too much, too little, insomnia, nightmares
❑ Smoking and tobacco use
❑ Spiritual, religious, moral, ethical issues
❑ Stress, relaxation, stress management, stress disorders, tension
❑ Suspiciousness, distrust
❑ Suicidal thoughts
❑ Temper problems, self-control, low frustration tolerance
❑ Thought disorganization and confusion
❑ Threats, violence
❑ Weight and diet issues
❑ Withdrawal, isolating
❑ Work problems, employment, workaholism/overworking, difficulties keeping job, dissatisfaction, ambition
❑ Other concerns or issues: _____
_____

Please look back over the concerns you have checked off and choose the one that you most want help with.

It is: _____

Oak Brook Counseling & Wellness

Client History Form

1010 Jorie Blvd. Suite 112 |Oak Brook, IL 60523 | 630.710.5729

Today's date_____ Name_____

Family History

Father: Living? Y N Date of Death_____ Cause:_____
Age:_____ Occupation:_____
Relationship as a child: Great_____ Good_____ OK_____ Fair_____ Poor_____
Relationship as a adult: Great_____ Good_____ OK_____ Fair_____ Poor_____
Mother: Living? Y N Date of Death_____ Cause:_____
Age:_____ Occupation:_____
Relationship as a child: Great_____ Good_____ OK_____ Fair_____ Poor_____
Relationship as an adult: Great_____ Good_____ OK_____ Fair_____ Poor_____ Step Parent:
Relationship as a child: Great_____ Good_____ OK_____ Fair_____ Poor_____
Relationship as an adult: Great_____ Good_____ OK_____ Fair_____ Poor_____
List siblings & rate relationship
_____ Great_____ Good_____ OK_____ Fair_____ Poor_____
_____ Great_____ Good_____ OK_____ Fair_____ Poor_____
Religion: _____ Religion of childhood_____
My childhood religious experience was : Great_____ Good_____ OK_____ Fair_____ Poor_____

Relationship History

Spouse's name_____ Spouse's Age_____ Spouse's Occupation_____
Years married_____
My marriage is ____great ____good ___OK ___fair ___poor
Number of marriages _____
Strengths of your present marriage_____
Challenges of your present marriage _____

If unmarried or otherwise single, are you currently in a relationship? Yes___ No____
If you are currently in a relationship, you consider it to be ____great ____good ___OK ___fair ___poor
If you are not in a relationship, when was your last relationship and how long did it last? (Month/year to month/year): _____
How would you rate that prior relationship? ____great ____good ___OK ___fair ___poor
Do you have significant relationships (such as friends, family) for support? _____
What is the nature and quality of those significant relationships?_____

Education/Employment

___Did not graduate ____GED/High school diploma ____Some college ____Bachelor's degree ____Advanced degree
Have there been any developmental delays or milestones? _____ If so, please describe_____
Current Employer, if any: _____ Your position_____ How long employed _____
Do you find your work satisfying? _____ Do you have challenges with your employment?_____
Have you had challenges with your previous occupations?_____ If so, describe_____

Military Service? YES__ NO__ Arrests? YES__ NO__ Convictions? YES__ NO__ Jail Time YES__ NO__ DUI/s YES__ NO__

Trauma and Other Major Incidents

Have you experienced any traumatic events? _____ If so, when_____ Who was involved_____
What is the nature of the trauma_____

Check all that are true from your childhood, if any:
____ Favoritism ____Physical abuse ____Sexual abuse ____Emotional abuse ____Parental rages
____Religious extremism ____I never felt good enough _____Parent unaccepting of lifestyle Other_____

Does anyone in your family have a history of: ___Mental illness ___Alcoholism ___Depression ____Schizophrenia ___Gambling ___Drug abuse ___Suicide attempts or completion

Treatment History

Have you had previous psychiatric hospitalizations Yes__No__ If so when_____
What was your diagnosis/es_____ and what symptoms did you experience? _____
Have you had previous mental health treatment, If yes, with whom?_____When?_____ Was it helpful? _____
Are you taking medications?_____ Allergies? _____
Starting with your childhood and proceeding up to the present, list all medical conditions:
_____ use back of paper if you need more room.

Current Concerns

What's your main concern for bringing you here today?_____
When did these concerns begin and how often do you experience them?_____
How long have you had these concerns? _____
What are your strengths? _____
What are your limitiations?_____
Do you have any ongoing medical conditions____ Please explain_____
Are you a registered gun owner? _____ Do you own a gun? _____
Anything else you think your therapist should know:
_____

Alcohol Use: Please answer yes or no

1. Do you feel you are a normal drinker? ("normal"—drink as much or less than most other people) Y/N
2. Have you ever awakened the morning after drinking the night before and found you could not remember the evening? Y/N
3. Does any near relatives or close friend ever worry or complain about your drinking? Y/N
4. Can you stop drinking without difficulty after one or two drinks? Y/N
5. Do you ever feel guilty about your drinking? Y/N
6. Have you ever attended a meeting of AA? Y/N
7. Have you ever gotten into physical fights when drinking? Y/N
8. Has drinking ever created problems between you and a near relative or close friend? Y/N
9. Has any family member or close friend gone to anyone for help about your drinking? Y/N
10. Have you ever gotten into trouble at work because of drinking? Y/N
11. Have you ever lost a job because of drinking? Y/N
12. Have you ever lost friends because of your drinking? Y/N
13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking? Y/N
14. Do you drink before noon fairly often? Y/N
15. Have you ever been told you have liver trouble such as cirrhosis? Y/N
16. Have you ever received help for drinking alcohol? Y/N
17. Have you ever had a DUI? Y/N
18. Have you ever been arrested because of other behavior while drinking? Y/N

Alcohol & Drugs/Medications

At what age did you have your first drink?____ At what age did you first try a drug?_____
Are you interested in quitting alcohol or drugs? Yes/No/NA
Check any of the following that you have experimented with or use:
___Barbiturates (downers) ___Tranquilizers (Valium, Xanax) ___Sleeping pills ___Amphetamines (uppers) ___Marijuana
___Cocaine ___Hallucinogens ___Opiates (heroin, morphine, Demerol) __Ecstasy __Inhalants ___Other drugs
___Over the counter medications (including vitamins and/or supplements)

Smoking

Current use of cigarettes_____ Are you interested in quitting smoking cigarettes? Yes__No__
Do you vape? Yes__ No__