

Essentially You Counseling and Wellness Services, LLC

125 Fairfield Way Ste 380 Bloomingdale, Il 60108

Identifying Information				
Last Name:	First:	Mi:		
Address:	City:	State:	Zip:	
<input type="checkbox"/> Home Phone:		<input type="checkbox"/> Cell Phone:		
Please check the box next to the contact number you would like us to use for verbal/electronic communications.				
Email Address:	<input type="checkbox"/> OK to send messages			
Date of Birth: / /	Age:	Gender Identity:	Marital Status:	
Social Security Number:				
Emergency Contact:		Phone:		
<input type="checkbox"/> By checking this box, I authorize for my emergency contact person(s) to be contacted in case of an emergency involving me.				
Employer:		Address:		
Primary Physician:		Referred by:		
Insurance Information: Please present insurance card at first visit. (I understand, and agree that, (regardless of insurance policy), I am responsible for the entire balance on my account. I understand that I am required to render payment for any current and past due balances at the time of service, this includes co-payments, missed appointment fees, co-insurance or any other balances that are the responsibility of the client, or client's parent or guarantor/insured.				
1 st Insurance Company:		Phone:		
Address:	City:	State:	Zip:	
*Name of Subscriber (policy holder):		Relationship:		
ID#	Group#			
*Subscribers Date of Birth / /	Male	Female		
*required to process insurance Claims				
2 nd Insurance Company:		Phone:		
Address:	City:	State:	Zip:	
*Name of Subscriber (policy holder):		Relationship:		
ID#	Group#			
*Subscribers Date of Birth: / /	Male	Female		
*required to process insurance Claims				
If insurance is not being used, please check here <input type="checkbox"/>				
Guarantor Information: (If Not Client: Person who is financially responsible)				
Last Name:	First:	MI:		
DOB:				
Address:	City:	State:	Zip:	
Relationship to Client:		Phone:		

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<p>I authorize Essentially You Counseling and Wellness Services, LLC to release any and all medical information deemed necessary for the purpose of processing insurance claims on my behalf. I understand that I am responsible for all charges not covered by insurance. I authorize the assignment benefits for all covered claims to be paid directly Essentially You Counseling and Wellness Services, LLC. A photocopy of this authorization shall be considered as valid and effective as the original.</p>		
Signature _____	Date	/ /

PERSONAL AND MEDICAL HISTORY

Thank you for choosing Essentially You Counseling and Wellness Services, LLC. You will be treated with courtesy and respect and we will do our very best to assist you in any way we can. Today we need your cooperation in giving us information that will assist your therapist with providing effective service delivery. Thank you for taking the time to answer the following questions fully and accurately.

Client Name _____

Reason for scheduling this appointment: _____

Personal History

Military History: No Yes – Dates of Service _____ Branch _____

Highest level of Education _____

Work / Occupational History: Employed Disabled Student Unemployed Other _____

Legal History: None Yes – Diversion Probation Parole (Current Past)

Crime victim: No Yes Referral needed for Legal Services: No Yes – Discuss this with your therapist

Medical History

How would you rate your overall health? Excellent Good Average Poor

Do you have any ongoing health issues? No Yes (please describe) _____

History of major surgeries or illnesses: _____

Date of last physical examination _____

Date of last treatment by a physician _____ Reason _____

Allergies: None Food Drugs Environmental Other (please specify for all items checked) _____

<i>All Current Medications</i>	<i>Dose</i>	<i>For what condition</i>

<i>Prior Psychiatric / Behavioral Medications</i>	<i>Dose</i>	<i>For what condition</i>

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Nutrition

Do you have any concerns about your nutrition? No Yes (please describe) _____

Briefly describe your daily diet (meals and snacks) _____

Have you experienced an unexplained weight gain or loss in the past 6 months? No Yes (please describe) _____

Pain Assessment

Do you experience ongoing pain? No Yes If yes, is it constant pain? No Yes Please describe your pain and its location: _____

Are you receiving treatment for your pain? No Yes If yes, describe the treatment and by whom: _____

Drug / Alcohol / Addictions Information

Do you or someone close to you have a problem with drugs, alcohol, gambling or other addictions? No Yes – if Yes, please describe _____

How much of the following do you consume in an average week? Beer _____

Wine _____ Mixed drinks _____

Drugs not prescribed for you (please list) _____

Do you have a problem with other drugs? No Yes – Please describe _____

Do you have a problem or concerns with the following? Tobacco Food Pornography Internet Sex Other

Do you consider yourself in recovery? No Yes – Length of time in recovery _____

Mental Health

Prior mental health outpatient services used or hospitalizations:

<i>Where</i>	<i>When</i>	<i>Purpose</i>	<i>Outcome</i>

Do you have any other issues or concerns that you would like your therapist to know about? Please describe: _____

We realize starting counseling is a major decision and you may have many questions. The following is intended to inform you of our policies. If you have questions or concerns, please ask and we will do our best to give you all the information you need.

Services offered: Essentially You Counseling and Wellness Services, LLC provides outpatient counseling services. We work with all age groups. Licensed practitioners provide individual, group, couples and family counseling, as well as case coordination.

By **initialing each line below**, you are agreeing to the terms and conditions set forth in each of the following sections.

INITIAL ASSESSMENT, DIAGNOSIS AND COUNSELING PROCESS

Initial Assessments take place at the first appointment. These sessions are used to gather data, complete intake information and determine appropriate course of care. Diagnostic impressions will be discussed with you by your therapist. If ongoing counseling is recommended, we will work to provide the best therapeutic methods and tools available. Regular attendance, active participation; in and out of sessions and overall commitment is ESSENTIAL and may inspire and encourage your growth.

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FEE AGREEMENT

I acknowledge that the full fee for Essentially You Counseling and Wellness Services, LLC sessions are as follows.

Initial Assessment	\$175.00	Individual Session(>37 min)	\$130.00
Family Session	\$150.00	Individual Session(>53 min)	\$150.00
Family Session w/o client	\$130.00	Group Sessions	\$50.00
Family Session (90 min)	\$190.00	Individual Session (90 min)	\$185.00
Missed Appointment(late cancel)	\$75.00		

- Fees are per session unless otherwise noted and are due at the time of service. Any return checks by the bank will incur a fee.
- Telephone consults less than 10 mins if not overused are complimentary.
- All other contacts (whether to clients, parents, school personnel, physicians, or other professionals, report writing, evaluations and other work necessary to provide and coordinate effective treatment, will be billed at quarter hour segments at \$150 per hour. Insurance does not cover this expense.
- Payment is due at the time of service. Any balance unpaid after 30 days will be charged to your credit card on file. Outstanding balances exceeding \$300 may result in a referral to another clinic, and the unpaid balances transferred to a collection agency. Any balances transferred to a collection agency will be assessed a 33% collection fee.
- If you receive an insurance payment meant for us we ask that you send that to us immediately.
- You are discouraged from requesting my participation in legal proceedings. If you become involved in such proceedings and do request participation you will be expected to pay for all professional time, including preparation and transportation costs. (if applicable office policy will be discussed and a separate legal fee form will be provided)

CLIENT RIGHTS

As a Client of Essentially You Counseling and Wellness Services, LLC you have the right to:

- Receive counseling services without regard to race, religion, sex, national origin, sexual orientation, age or disability.
- Be treated with dignity and respect at all times.
- Be accepted for counseling only if the agency has the professional staff to meet your needs.
- Be referred appropriately when the agency is not able to meet your needs in a reasonable and timely manner.
- Be referred for appropriate assessments/evaluations.
- Participate in the development of an individualized treatment plan with periodic review of the plan.
- Be informed of the cost of the services and receive appropriate care regardless of the source(s) of payment.
- Confidentiality of information as prescribed by law.
- In the event of incapacitation, death or termination of your therapist at Essentially You Counseling and Wellness Services, LLC during your care, your records will remain in our possession and a new therapist will be made available to you. If you desire to transfer care outside of this practice, you may sign a release of records and we will release the initial intake and most recent progress notes.
- Voice a grievance or complaint about treatment and/or staff without fear of reprisal or discrimination, and have the grievance investigated. The grievance procedure is:
 - Discuss the concern with your therapist.
 - Failing resolution, request a meeting with Erin Redfern, LCPC, President. The complaint should be presented in writing at this time.

CLIENT RESPONSIBILITIES

- Participate actively in the counseling process as recommended by your therapist.
- Give 24-hour notice if an appointment cannot be kept. Failure to do so will result in client being billed for the session.
- Notify the office in the event of change of address, phone number or insurance.

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- Provide 7 business days notice if you are requesting copies of any or all medical records.
- Maintain a professional relationship with your therapist. Therapists will not accept friend requests on any social media platform.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

- If your clinician has cause to believe that you are likely to harm yourself, he/she may take action necessary to protect your safety by contacting your significant other, law enforcement officers or a physician.
- If your clinician has cause to believe you are likely to harm another person, he/she may take action necessary to protect their safety by contacting the individual that has been threatened, law enforcement or a physician.
- If your clinician has cause to believe a child has been or may be abused or neglected, the clinician is required to make a report to the appropriate state agency. (Illinois State Law requested that this be reported to the Department of Children and Family Services).
- If your clinician has cause to believe an elderly or disabled person has been or may be abused, neglected, or subject to financial exploitation, the clinician is required to make a report to the appropriate state agency.
- Information disclosed about a person from whom you sought counseling behaving toward you in a sexually inappropriate manner must be reported (your identity may remain anonymous at your request).
- If your records are requested by a valid subpoena or court order, we must respond.
- Please note that therapists are often not immediately available to take phone calls. Please leave a message and your therapist will respond to your call as soon as they are able. IF there is a clinical emergency that you cannot wait for a return phone call please call 911 or go to your nearest emergency room.
- If we see you in public (store, event, etc.), we will not approach you to say hello to protect your confidentiality.
- If you choose to email or text, please limit the contents to issues such as cancellation or change in appointment time. Email and text messages are not guaranteed confidential.

INFORMED CONSENT FOR COUNSELING

- As a client, you need to be informed of certain key aspects involving all counseling situations. Counseling attempts to teach you alternative ways of coping with problems. As such, no guarantee exists that you will automatically feel better from coming to counseling. Please initial, acknowledging that you understand this information and give voluntary consent to participate in therapy.
- If the client is a minor child, I understand that as the parent / legal guardian, I will be advised regarding the client's welfare during counseling.

CONSULTATION

By initialing above, I authorize my therapist to use team consultation to discuss information about my care and treatment, thereby ensuring optimal treatment while engaged in the therapeutic process. Limited license practitioners are licensed to practice only under supervision of a fully clinical professional. If you are seeing a limited license practitioner your case will be regularly reviewed with the assigned clinical supervisor and care will be directed by the fully clinical professional. If you have questions, feel free to direct those to your provider.

CANCELLATION AND NO-SHOW POLICY

- An agreement will be made between therapist and client/parent(s)/legal guardian regarding the frequency of therapy.
- The frequency of therapy will be developed with the intent of maximizing the therapeutic effect of treatment. Cancellations will compromise progress. Also, cancelled appointment times can be given to other clients.
- When the need arises to cancel an appointment, we request notification as soon as possible, but preferably within 24 hours before the scheduled appointment time if possible otherwise client will incur a charge of 75 dollars.
- Therapist cancellations will not count against client.

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Client Signature (age 18 and over)

Date

Client Signature (age 12-17)

Date

Client Guardian Signature (for minors)

Date

Client Printed Name

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, and have been given a copy of, the Privacy Notice as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the notice I do not understand.

Client Name: _____

Responsible Party Name (if client is a minor): _____

Relationship to Client: _____

Signature: _____ Date: _____

I/We have read the above information in full and agree to these terms for the receipt of counseling services.

Signature _____ Date _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the client's signature acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Initials: _____ Date: _____

Reason: _____
