Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

Identifying Information (Please complete using black ink only)

Last Name:__________________________ First:_____________________________ Mi:_____________________________
Address:__________________________ City:______________________________ State:____________ Zip:___________
☐Home Phone:__________________________________ ☐ Cell Phone:____________________________________
Please check the box next to the contact number you would like us to use for verbal/electronic communications.

Email Address:____ ☐ OK to send messages
Date of Birth:____________________ Age:__________ Gender Identity:______________ Marital Status:______________
Social Security Number:__________________________
Emergency Contact:____ Phone:_____________________________________
☐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.

1st Insurance Company:____ Phone:_____________________________________
Address:______________________________ City:_________________ State:________________ Zip:________________
*Name of Subscriber (policy holder):_____________________________ Relationship:______________________________
ID#___________________________ Group#____
*Subscribers Date of Birth:__________________________
***required to process insurance Claims**

2nd Insurance Company:____ Phone:___________________________________
Address:______________________________ City:___________________ State:______________ Zip:________________
*Name of Subscriber (policy holder):________________________________ Relationship:____________________________
ID#___________________________ Group#____
*Subscribers Date of Birth:__________________________
***required to process insurance Claims**

If insurance is not being used, please check here □

Guarantor Information: **(If Not Client: Person who is financially responsible)**

Last Name:__________________________ First:_____________________________ MI:_____________________________
DOB:_______________________________
Address:__________________________ City:______________________________ State:______________ Zip:__________
Relationship to Client:____ Phone:___________________________________

Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

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 ☐ Probation ☐ Parole (☐ Current ☐ Past)

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

Are there any spiritual or cultural variables we should be aware of?________________________________

____

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)______________

____

All Current Medications	*Dose*	*For what condition*

Prior Psychiatric / Behavioral Medications	*Dose*	*For what condition*

Are there any significant family medical/mental health issues we should be aware of?______________________

____

____

Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

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:

Where	*When*	*Purpose*	*Outcome*

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.

Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

____________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.

- Provide 7 business days' notice if you are requesting copies of any or all medical records.

______________**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.

Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

______________________________________ ___________________
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**___________________

Essentially You Counseling and Wellness Services, LLC
125 Fairfield Way Ste 380 Bloomingdale, Il 60108

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: ____
____
____
____
____
____