COUNSELING FOR EMPOWERING CHANGE, LTD.

ANN CARLSON, LCSW

630-318-2805, ann@anncarlsonlcsw.com, anncarlsonlcsw.com

Oakmont Business Center

825 N. Cass Avenue, Suite 112

Westmont, IL 60559

CLIENT BACKGROUND INFORMATION

Date_____ *FOR OFFICE USE ONLY: DX* _____

Client Name_____ Date of Birth_____

Status: Married Single Divorced Widowed Domestic Partner Gender _____

Occupation/Grade_____ Employer/School_____

Home Address_____

City_____ State_____ Zip_____

Home phone_____ Cell phone _____ _____

Work phone_____ Email_____

Best place for me to leave a message (circle all that apply) Home Cell Work Email Text

If you are using insurance, please complete the following:

Insurance Company_____ID# _____Group #_____

Insurance Company Address_____

City_____State_____Zip_____

Policy Holder Information (if different than client):

Name_____ Date of Birth_____

Address _____

City_____State_____Zip_____

Relationship to Client _____Policy Holder Employer_____

I/We consent to Counseling For Empowering Change, Ltd. to release all information requested by my insurance company, managed care company or EAP to secure benefit payments. I consent to the use of this signature on all insurance submissions.

Signature_____ Date_____

Signature_____ Date_____

I/We consent to the payment of benefits directly to Counseling For Empowering Change, Ltd. who accepts assignment. It is understood the undersigned has the responsibility for payment of services. Assignment of benefits does not release the undersigned from responsibility of payment.

Signature_____ Date_____

Signature_____ Date_____

SYMPTOM CHECKLIST

Review the following symptoms and mark the symptoms you are experiencing.

PHYSICAL SYMPTOMS:

___headaches	___insomnia	___excessive sweating	
___muscle ache	___daytime drowsiness	___increased appetite	
___stomach aches	___diarrhea/constipation	___poor appetite	other_____

BEHAVIORAL SYMPTOMS:

___increased cigarette use	___cutting	___low motivation/energy	
___increased alcohol use	___skin picking	___excessive energy	
___increased illegal substance use	___binge eating	___poor self care	
___excessive spending	___impulsive risk taking	___excessive exercise	
___restricting food intake	___avoiding social contacts	___hair pulling	
___poor concentration	___forgetfulness	___purging	other_____

EMOTIONAL SYMPTOMS:

___easily frustrated	___cry easily	___changing moods	
___anger	___worried	___thoughts of suicide	
___feel something bad will happen	___hopeless	___thoughts of homicide	
___intrusive/upsetting thoughts	___racing thoughts	___irritable	
___scared	___lonely	___sad	other_____

Do you currently feel suicidal?_____Do you have a plan and a means to kill yourself? _____

Do you currently feel homicidal?_____Do you have a plan and a means to kill someone else?_____

CONSENT FOR TREATMENT AND GENERAL POLICIES

Starting therapy is a big decision and you may have questions. We will do our best to answer any of your questions or concerns. This form explains our policies, state and federal law and your rights about mental health treatment. You should be aware that therapy is designed to be helpful, and it may also be difficult and painful at times.

CONFIDENTIALITY AND EMERGENCY SITUATIONS

Our conversations and our notes are not shared with anyone without your written permission, with these exceptions:

1. Diagnosis and dates of service shared with your insurance company to process your claims.
2. Information you tell us about physical, sexual or elder abuse; then, by Illinois state law, we will report this to the appropriate welfare agency.
3. When you sign a release of information to have specific information shared.
4. If you tell us you are in danger of harming yourself or others.
5. Information shared with our supervisor or consultant.
6. When required by law.

Please be informed, Counseling For Empowering Change, Ltd. is not able to provide emergency services in times of imminent crisis. If you are in need of emergency services, please contact your medical doctor, your psychiatrist, call 911 or go to your nearest emergency room. DuPage County offers crisis intervention services and can be reached at 630-627-1700.

Please know you have the right to review and receive copies of your client file. This file can be sent to another mental health professional, treatment facility, school or medical doctor, only with your written consent.

I have read and understand the confidentiality policy and its limits and rights to records.

Signature_____ Date_____

PHYSICIAN CONSENT

I hereby authorize Counseling For Empowering Change, Ltd. to discuss my mental health care with my primary care physician. I also authorize the release of any medical documentation to my primary care physician for the purpose of treatment.

Primary Care Physician_____ Phone_____

Address_____ City_____State_____ Zip_____

Signature_____ Date_____

It is your right to waive notification disclosing mental health care to your primary care physician. If you wish to waive notification, please indicate your reason as stated below:

☐ **I WAIVE NOTIFICATION** of my primary care physician to inform him/her I am seeking or receiving mental health services and direct you **NOT** to notify him/her.

☐ I do not have a primary care physician and do not wish to see one at this time. I therefore **WAIVE NOTIFICATION** to inform notification of a primary care physician.

Notice of Privacy Practices:
I have received and been provided to review the notice of privacy practices.

Signature_____ Date_____

Consent for treatment of a minor:
As the custodial parent or guardian of _____
I(we) authorize and consent to services with Counseling For Empowering Change, Ltd.

Signature_____ Date_____

ELECTRONIC COMMUNICATION

Electronic communication in the form of text message, email or voice mail cannot be guaranteed as confidential. Knowing this, please limit your electronic communication to appointments or schedule changes. If you wish to speak about your treatment at a time other than our scheduled appointment, please leave a brief message and we will contact you by phone within 24 hours to address your concerns.

If you choose to leave us information about your treatment, please understand the limits of confidentiality and the risks associated with it.

Please do not disclose information if you are at risk of harm to yourself or someone else via text, email or voicemail, since a timely response to a life threatening emergency cannot be guaranteed. If you are at risk of harm and need immediate assistance, please contact your medical doctor, go to the nearest emergency room or call 911.

I have read and understand the electronic communication policy.

Signature_____ Date_____

PAYMENT AND FEES

Payment is due at the time of service. You understand you are fully responsible for all fees for services during the treatment period. If you are using insurance, it is your responsibility to understand your benefits, coverage and limits of coverage. If authorized by you to do so, Counseling For Empowering Change, Ltd. will submit claims to your insurance, but the final responsibility for payment is yours. Cash, check or credit card are acceptable forms of payment for services. To ensure payment, all clients are required to complete the credit card authorization section.

Fees:

Initial assessment - $150
60-minute session - $130
45-minute session - $110

No show or cancellation with less than 24 hours notice - $60

I have read and understand the payment policy and fee for late cancellation or missed without notification session.

Signature_____ Date_____

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Credit Card Authorization Form

Clients are required to have a credit card on file with Counseling For Empowering Change, Ltd. to receive services.

If there is an unpaid balance, the credit card on file will be charged the unpaid balance 30 days after the invoice due date.

The credit card on file will be charged $60 for a session cancellation less than 24 hours or a no show to a scheduled appointment.

By signing this form, you acknowledge you understand and agree to the above authorization information.

_____ _____

Signature to acknowledge **Date**

Credit card information:

Circle type of card: **American Express** **Discover** **MasterCard** **Visa**

Cardholder's name (as it appears on the card): _____

Credit card account number: _____

Expiration date: _____ **Security code on back of card:** _____

Billing address: _____

_____

Cardholder's phone numbers: cell:_____ **home:** _____

work: _____