CLIENT INFORMATION

Psychotherapy

BASIC INFORMATION

FIRST ______________________________ MI ________ LAST NAME ______________________________

PREFERRED NAME – HOW YOU WISH TO BE ADDRESSED ____________________________________

DATE OF BIRTH _____/_____/___________ AGE ________

GENDER IDENTIFICATION ☐Female ☐Male ☐OTHER _________________________

MARITAL STATUS ☐Single ☐Civil Union ☐Married ☐Divorced ☐Separated ☐Widow

CONTACT INFORMATION

STREET ____ Home Phone _____________________

CITY ____ Work Phone _____________________

STATE _________________ ZIP ____________________ Cell Phone ___________________________

EMAIL ADDRESS ____

WHERE MAY WE LEAVE A MESSAGE? ☐Home ☐Work ☐Cell ☐Email

REFERRAL

WHO MAY I THANK FOR THEIR REFERRAL? ____

CLIENT INFORMATION

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INSURANCE INFORMATION

PRIMARY INSURANCE

COMPANY NAME ________________________________ SUBSCRIBER ☐SELF ☐OTHER

If Subscriber is Other, Please provide information for subscriber

FIRST ________________________ MI ___________ LAST NAME _____________________

SUBSCRIBER ADDRESS ☐Same as Client

STREET ___________________________________ Subscriber Phone __________________

CITY ____

STATE __________________ ZIP ____________ Subscriber DOB ____________________

INSURANCE ID # ___________________________ GROUP # _________________________

SECONDARY INSURANCE

COMPANY NAME _____________________________ SUBSCRIBER ☐SELF ☐OTHER

If Subscriber is Other, Please provide information for subscriber

FIRST ________________________ MI ______ LAST NAME __________________________

SUBSCRIBER ADDRESS ☐Same as Client

STREET ________________________________ Subscriber Phone _____________________

CITY ____

STATE __________________ ZIP ______________ Subscriber DOB __________________

INSURANCE ID # ____________________________ GROUP # ________________________

CLIENT INFORMATION

Psychotherapy

PRIMARY CARE PHYSICIAN INFORMATION

PCP NAME ______________________________

ADDRESS ______________________ CITY ______________

STATE ________ ZIP ____________ PHONE ______________

EMERGENCY CONTACT INFORMATION

FIRST ______________ LAST NAME ______________

RELATIONSHIP ____________ PHONE NUMBER ______________

I hereby authorize MHB Counseling/Jon Hsieh, MSW, LCSW, to furnish my insurance company all information that the insurance company may request concerning my present diagnosis and treatment. I hereby assign MHB Counseling/Jon Hsieh, MSW, LCSW, all monies to which I am entitled for expenses relative to the services provided. I understand that I am financially responsible to MHB Counseling/Jon Hsieh, MSW, LCSW, for charges not covered by the insurance.

CLIENT SIGNATURE ______________________ DATE ____________

INFORMED CONSENT

Psychotherapy

PSYCHOLOGICAL SERVICES

As you consider beginning treatment, you should be aware of the possible benefits and risks of psychotherapy. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, anger, guilt, frustration, loneliness and helplessness. In addition, individuals, couples, and families may find that the counseling process takes them to a place of making important life decisions. While your therapist will honor and respect your right to make decisions for yourself, important people in your life may not agree with a direction you decide to pursue. Those experiences are likely to produce new opportunities as well as unique challenges. Psychotherapy has been shown to have benefits for those who engage in it. Therapy can lead to significant personal growth, better relationships, solutions to specific problems, and significant reductions in feelings of distress. Don't hesitate to discuss treatment goals, methods, or your experience with your therapist.

PROFESSIONAL FEES & AVAILABILITY

Fees reflect specialized training and experience. Unless arranged in advance or dictated by insurance agreements, fees for a typical session are as follows: Initial Evaluation Sessions - $185; Individual/Conjoint Psychotherapy Sessions - $150/$130 per the length of the session. There may be fees charged for other services that can include report writing, telephone conversations lasting 20 minutes or longer, attendance to meetings with other professionals you have authorized, and the preparation of records or treatment summaries. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for professional time spent even if they are called to testify by another party. Fees for preparation and attendance at any legal proceeding are $250 per hour, including travel time.

Payment is due at the time of service. Methods of payment accepted include cash, checks, debit and credit cards. If you are using an HSA Debit Credit Card, every effort will be made to notify you should this method of payment not be accepted or work with our systems – in which case you will be asked to provide an alternative payment method. If you need to cancel and/or change a scheduled

appointment, please provide at least 24 hours notice. If you do cancel within 24 hours or do not show for your scheduled appointment, you will be charged the full fee for the appointment. Be aware that if you are using insurance, insurance companies will not cover late cancelled or missed appointments. You will fully responsible for the fee if you do not give 24-hour notification (unless we both agree that you were unable to attend due to circumstances beyond your control).

Discuss availability for appointments with your therapist. Phone calls are generally returned as soon as possible, usually within 24-48 hours with the exception of weekends and holidays. In the event your therapist is unavailable in an emergency, go to the nearest emergency room or contact your county's crisis intervention services: DuPage County (630) 627-1700; Will County – Bolingbrook, IL (630) 759-4555; Will County – Joliet, IL (815) 722-3344; Kane County (630) 966-9393; Kendall County (630) 553-1400. You may also call 911 or your primary care physician or psychiatrist.

INSURANCE REIMBURSEMENT

Please consider carefully whether or not to use health insurance benefits to pay for psychotherapy services. You always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage. Health insurance policies usually provide some coverage for mental health treatment. Every effort will be made to assist you with pursuing the benefits to which you are entitled. You remain responsible for all charges and fees not paid for by insurance unless otherwise agreed in advance. These include deductibles, co-payments, co-insurance payments, non-covered, ineligible, or unauthorized services.

You should be aware that most insurance companies require you to authorize providing them with a clinical diagnosis. Additionally, insurance companies can require additional clinical information including treatment plans and treatment summaries or, in rare cases, copies of the entire record. This information will become part of their records. Insurance companies affirm to keep such information confidential. However, MHB Counseling has no control over the use of that information once it is in their possession.

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PROTECTED HEALTH INFORMATION (PHI)

The laws and standards of my profession require that I keep and use protected health information in a manner consistent with the rules for confidentiality of mental health records – recorded in the Illinois Mental Health and Developmental Disabilities Confidentiality Act and in the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA). You have the right to inspect and/or receive a copy your health record or a summary can be prepared for you. It is recommended that you review your records in the presence of your therapist to address any questions and/or discuss the contents. Clients will be charged an appropriate fee related to responding to information requests. If, after reviewing the record, you believe that any statement is in error, you have the right to add a written amendment stating why an entry is in error and it will be included in your health records. Anytime that section of your record is released, the amendment must be included.

The law protects the privacy of all communications between therapist and client and protected health information may only be released with your written permission. There are, however, exceptions to confidentiality. Protected Health Information may be released without consent when 1) a therapist is disclosing information to a supervisor, consulting therapist, and/or member of treatment team participating in the provision of services, a record custodian, or a person acting under the supervision of the therapist; 2) when a therapist believes there is a clear and immediate present danger to one or more persons; 3) when disclosure is necessary to provide a recipient with emergency medical care or access to needed benefits when the recipient is not in a condition to waive or assert his or her rights; 4) when abuse or neglect of a child is suspected; 5) when a therapist is consulting with an employer, attorney, professional liability company, or other relevant business associate concerning the care or treatment he or she has provided, including disclosure to business associates who may help us pursue payment (but each of these recipients shall be held to HIPAA privacy standards and may not re-disclose the information); 6) when a recipient introduces his or her mental condition or any aspect of services received for such condition as an element of a claim or defense; and, 7) in certain other legal situations where the court has decided that disclosure is

INFORMED CONSENT

Psychotherapy

directly relevant to the issue being investigated. Furthermore, as part of the Illinois Firearm Concealed and Carry Act (PA98-063), clinicians are required to notify the Illinois Department of Human Services of anyone who is determined to be a "clear and present danger" to themselves or others or determined to be developmentally or intellectually disabled.   Please ask if you have any questions and/or concerns about confidentiality.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE ___________________________________ DATE ________________________
(Age 12 or over)

SIGNATURE ____ DATE ______________________
(Parent/Guardian for minor child)

PCP NOTIFICATION

Psychotherapy

Unless you waive this notification, Illinois Law requires your therapist to notify your Primary Care Physician, if you have one, that you are seeking or receiving psychotherapy services. MHB Counseling LLC believes that it is desirable for your therapist to confer and work together with your primary care physician in your treatment. Please indicate if you would like your therapist to contact your physician by checking the appropriate box below and providing the requested information.

☐ I AGREE for you to notify my Primary Care Physician that I am seeking or receiving psychotherapy services. I will *also* sign an additional form authorizing the release of Protected Health Information for MHB Counseling to communicate with my Physician.

☐ I WAIVE notification to my Primary Care Physician that I am seeking or receiving psychotherapy services and I direct MHB Counseling not to notify my PCP.

☐ I do not have a Primary Care Physician and do not wish to confer with one. I THEREFORE WAIVE notification to my Primary Care Physician that I am seeking or receiving psychotherapy services.

PRIMARY CARE PHYSICIAN INFORMATION

(Please provide PCP information unless waiving notification of PCP)

PCP NAME ______________________________

ADDRESS ______________________ CITY ______________

STATE ________ ZIP ____________ PHONE ______________

CLIENT SIGNATURE ______________________ DATE ____________

THERAPIST SIGNATURE ______________________ DATE ____________

Email/Text Messaging Agreement

Psychotherapy

We understand that **email** and **text messaging** offers an easy and convenient way for clients and therapists to communicate with one another. In many circumstances, such as for confirming appointments, text messaging has advantages over telephone calls (or messages back and forth) and other means of communication.

However, we need to caution you that there are some important disadvantages as well. Most importantly, given that many text messages now show up on computers as well as phones, the latest HIPAA rules consider that to be Protected Health Information (PHI) if associated with your treatment here, and we cannot guarantee the security of such unencrypted electronic communications. This means that emails and/or text messages are not confidential and are comparable to sending a postcard through the mail.

Therefore, emails and/or text messages should not be used to communicate sensitive health information, which naturally may include mental health and substance abuse details. In some circumstances, your email and/or text messages may become part of your health record. Finally, emails and/or text messaging is not a substitute for seeing your therapist. If you think you need to be seen, please call and schedule an appointment.

With this in mind, we still consider emails and/or text messaging to be an acceptable part of our communications with clients. To use it with you, however, we need to document that we have informed you of the risks in using emails and/or text messages communication to you and your PHI—and have secured your consent to send and receive emails and/or text messages with MHB Counseling LLC.

Client Name: ____

Email Address: ____

Mobile Phone #: ____

Email/Text Messaging Agreement

Psychotherapy

The email address and/or mobile phone number provided above are authorized for purposes of receiving and responding to email and/or text communications. These will be the only ones used for purposes of email and/or text communications. Should either the email address or mobile phone number change, please notify MHB Counseling LLC as soon as possible with an update.

Client Signature: ______________________________ Date: ______________

Therapist Signature: ______________________________ Date: ______________

CREDIT CARD AUTHORIZATION

I, hereby, authorize MHB Counseling LLC to process payments on my VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, or HSA DEBIT CREDIT CARD for my sessions with Jon Hsieh, MSW, LCSW (for fee payments, co-pays, co-insurance, late cancellations and/or missed appointment charges and outstanding balances).

I understand that if my card declines, MHB Counseling LLC may put my VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, or HSA DEBIT CREDIT CARD through on another day when funds become available.

I also understand that this will in no way compromise my ability to dispute a charge or question my insurance company's determination of payment.

CLIENT INFORMATION

FIRST ______________________________ MI ________ LAST NAME ______________________________

STREET ____

CITY ____

STATE _________________ ZIP ____________________

CARD HOLDER INFORMATION

☐ Card Holder is CLIENT ☐ Card Holder is OTHER

FIRST _____________________________ MI _____________ LAST NAME _________________________

Card Holder Billing Address ☐ Same as Client

STREET ____ Billing Phone _____________________

CITY ____

STATE __________________ ZIP ____________________

CREDIT CARD AUTHORIZATION

CARD INFORMATION

CARD NUMBER ____

EXPIRATION DATE (MM/YY) ____________________ SECURITY CODE ________________

SIGNATURE ________________________________ DATE ____________________

MHB Counseling, LLC
800 West Fifth Avenue, Suite 101-H, Naperville, Illinois 60563 1 East Merchants Drive, Suite 207, Oswego, IL 60543
(630) 384-9529 l mhb-counseling.com

MEDICATION LIST

We understand that some clients may utilize medication prescribed by their primary care physician or psychiatrist to address various kinds of symptoms. Please take a moment to document what current medications you are taking.

Medication Name	Dosage	Frequency	Route of Administration

Should anything in your medication regimen change, such as the dosage of a medication, the discontinuation of a medication, the addition of a medication or a change in frequency, please notify your therapist.

Client Signature: ____ Date: ___________________