

**CLIENT INFORMATION**

Patient Name: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
 Gender:  Male  Female Marital Status:  Married  Single  Other  
 Work Status:  Employed  Unemployed  Full-time Student  Part-time Student  
 Employer/School & Address: \_\_\_\_\_  
 Relationship to Insured:  Self  Spouse  Child  Other  
 Home Phone: \_\_\_\_\_ May we leave a message? Y N  
 Work Phone: \_\_\_\_\_ May we leave a message? Y N  
 Cell Phone: \_\_\_\_\_ May we leave a message? Y N  
 Other attending family members: \_\_\_\_\_  
*Others you wish to have access to your appointment schedules, and/or billing information. (If you elect this option we will provide releases that spell out the limits of information to be released.)*  
 Name : \_\_\_\_\_ Phone: \_\_\_\_\_  
 Name : \_\_\_\_\_ Phone: \_\_\_\_\_

**Referral Information**

How did you (Circle One)  
 hear about us: Friend Professional Web Search Insurance. Co. Phone book Other  
 Referred by: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**Primary Care Physician Information**

PCP Name: \_\_\_\_\_  
 PCP Address: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_

**If you are filing insurance, please complete below**

Insured's Name & Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Insured's Employer & Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ SSN: \_\_\_\_\_  
*No need to complete the following if you have an insurance card we may photocopy.*  
 Ins. Company Name: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Member ID#: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_  
 Plan Name#: \_\_\_\_\_ Reference #: \_\_\_\_\_

For office use only DSM: \_\_\_\_\_ Authorization #: \_\_\_\_\_



**Centennial  
Counseling  
Center**

1120 E. Main St.  
Cedar Crossing  
Building  
St. Charles, IL 60174  
630.377.6613  
Fax 630.377.6225

1 E. County Line Road  
Arrowhead  
Professional Building  
Sandwich, IL 60548  
815.786.8606  
Fax 815.786.1541

110 East Countryside  
Parkway  
Yorkville, IL 60560  
630.553.1600  
Fax 630.553.7993

(Please complete for each attending person.)

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Form: \_\_\_\_\_

Please check how often these symptoms occurred *in the last six months*. If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms *in the last six months*.

SYMPTOM	Never or rarely	A few times per month	Nearly every day	SYMPTOM	Never or rarely	A few times per month	Nearly every day
Guilt Feelings				Hopeless about future			
Worrying				Thinking about death			
Too much energy				Thinking about suicide			
Aggressive				Problems with family members			
Uncontrolled temper				Brooding about the past			
Afraid of work/school				Crying excessively			
Afraid of leaving house				Feeling down or sad			
Sleep walking				Nightmares			
Problems falling asleep				Feeling anxious			
Problems staying asleep				Feeling panicky			
Memory loss				Problems with anger			
Trouble making decisions				Feeling jealous			
Feeling alone				Feeling impatient			
Difficulty concentrating				No confidence in self			
Sudden mood changes				Shortness of breath			
Restlessness				Fast heart beat			
Easily Distracted				Chest pains			
Problems getting along				Feelings of unreality			
Feeling worthless				Lying			
Overly tired				Problems at home			
Poor or no appetite				Alcohol use			
Over eating				Drug use			
Bingeing				Blackouts			
Food preoccupation				Stomach problems			
Vomiting				Uncontrolled thoughts			
Sleeping too much				Uncontrolled behavior			
Hearing voices				Physical abuse of self or others			
Problems at work/school				Emotional abuse of self or others			
Stealing				Other:			

Medications or other medical issues (allergies, thyroid, diabetes, etc.) we should know about: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

## INTAKE INFORMATION

### **Before beginning treatment, you should be aware of the possible benefits and risks of counseling services.**

The majority of individuals, couples, and families who obtain behavioral health services benefit from the process. The therapeutic process is generally quite useful and can result in improved mood, increased self-esteem, and greater ability to make choices that facilitate physical, emotional, and relational health, but some risks do exist. In the course of the therapeutic process individuals may experience unwanted feelings. If feelings of unhappiness, anger, guilt, frustration, or deep pain arise in counseling, the experience can be unexpected and distressing. 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. These experiences are likely to produce new opportunities as well as unique challenges. Don't hesitate to discuss treatment goals or procedures, especially if you experience unexpected discomfort or are concerned about an outcome of treatment.

### **Hours & Availability:**

The Centennial Counseling Center phone line is either answered by our staff or switched over to a voicemail system 24 hours a day, 7 days a week. Therapists are expected to return calls promptly, but at times are unable to return calls as soon as you may require. Some therapists are not available on weekends. Discuss availability with your therapist. In the event your therapist is unavailable in an emergency, go to the nearest local emergency room or contact one of the following crisis intervention services: Kane Co: 630/966-9393; Kendall Co: 630/553-1400; DeKalb Co: 866/242-0111; DuPage Co: 630/627-1700. You may also call 911 or call your primary care physician or psychiatrist.

### **Payment and Fees:**

*Payment is expected at the time services are rendered.* This office accepts cash, checks, debit cards, and credit cards. If payment is not made at the time of service, we ask you to settle the bill prior to the next session. Appointments are generally 45–50 minutes in duration. *You are responsible for the fees charged.* Any change in the fee will be discussed with you beforehand. In those cases where the client is a minor child, the parent/guardian is responsible for the bill. *If you need to cancel or change an appointment, notify the office at least 24 hours prior to the therapy appointment or group session in order to avoid a charge for the missed appointment or late cancellation. Please note that insurance companies will not cover missed or no-show appointments. You will be fully responsible for this charge if you do not give the proper 24-hour notification.*

Intake session: \$165.00

Ongoing sessions: \$125.00

Late cancellations/no-show: \$125.00

### **Insurance Fees and Diagnosis:**

You should be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis. This information will become part of the insurance company files, and in all probability some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, our office has no control over its use. It is important to remember that you always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage.

It is in your best interest to verify the details of your health insurance policy and share that information with our Business Office. Centennial's Business Office will assist you in verifying your coverage and generate an accurate insurance claim form that will be sent directly to your insurance company. You remain responsible for all charges not paid by insurance unless otherwise agreed *in advance*. You **remain personally responsible for deductibles, co-payments, coinsurance, non-covered, ineligible, or unauthorized services.** Please note that not all therapists at Centennial Counseling Center may be participating with your plan. We recommend that you verify your coverage prior to or within 24 hours of the first appointment to be sure that your therapist is a covered provider and these services will be covered.

### **Other Fees:**

Insurance companies cover the cost of *psychological testing* very inconsistently. We will do our best to verify in advance if the cost of a psychological test will be covered, but in general you should expect to pay out-of-pocket for any psychological test you complete. There is a \$20 charge on all *returned checks*. NSF checks must be replaced with cash, certified check, or money order. Delinquent accounts may be referred for collection and credit reporting as well as interest added to balances over 60 days. You are responsible for all attorneys' fees and court costs incurred by Centennial Counseling Center in connection with the recovery of unpaid counseling fees.

## PRIVACY NOTICE

At Centennial Counseling Center (“CCC”) we are committed to treating and using protected health information responsibly. This Notice describes the procedures we use to protect your information, and the circumstances under which your personal health information may be disclosed. It also describes your rights as they relate to this information. The rules for confidentiality of mental health records are recorded in the *Illinois Mental Health and Developmental Disabilities Confidentiality Act* and in the privacy rules of the *Health Insurance Portability and Accountability Act*. We strongly suggest you review these provisions in order to fully understand our procedures and your rights.

### **We strive to protect your personal health information.**

At CCC, every effort is made to keep your personal health information private. Some of our procedures will be evident to you. For example, when you call to discuss an issue with office staff, we may ask you for some piece of identifying information to confirm your identity. Others happen behind the scenes. Computer data is password protected at the work stations and encrypted if it is transferred electronically. Files are secured in locked cabinets at night, and every effort is made to prevent others from viewing your personal health information when it is being worked on by staff members during the day. If you have any concerns about your privacy, please bring them to our attention.

### **You are entitled to copy or review your mental health records.**

You have the right to inspect and/or copy your health record. If, after reviewing your record, you believe that any statement is in error, you have a right to request that the person who made the entry make a correction. Anytime you request a revision, your request and the action taken must be noted in the record. If a professional chooses to stand by a statement with which you disagree, you have the right to add a written amendment stating why you believe the entry is in error. Any time that section of the record is released, your amendment must be included.

### **The following individuals can access a mental health record without written authorization.**

1) an adult recipient of services; 2) the parent or guardian of a child who is under 12 years of age; 3) the recipient if he is 12 years of age or older; 4) the parent or guardian of a recipient who is at least 12 but under 18, if the recipient does not object or if the therapist does not find that there is a compelling reason for denying access, but *nothing in this statement is intended to prevent a parent or guardian of a child who is at least 12 but under 18 from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed*; 5) a legal guardian of a recipient who is 18 or over; 6) an attorney, guardian ad litem, or power of attorney or other person who is legally authorized to access the records. We are happy to provide you with assistance in understanding the record.

### **In the following circumstances, we may release your records without your permission.**

There are circumstances that impose limitations on a client’s right or ability to maintain privileged communication. A therapist may disclose a record without consent: 1) to a supervisor, consulting therapist, or member of the staff 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 a clear and immediate danger exists 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 redisclose 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 directly relevant to the issue being investigated.

### **Additional rights.**

You have the right to request restrictions on certain uses and disclosure of personal health information. However, CCC is not required to agree to a requested restriction, and in some situations, is prohibited by law from agreeing to a requested restriction. You have the right to request and receive an accounting of disclosures that we make to other individuals.

CCC reserves the right to change the terms of its Privacy Policy and to make the new Policy provisions effective for all personal health information that it maintains. You will be notified of any changes to the Policy.

If you believe your privacy has been violated, first bring the matter to the Office Manager of the office where you are receiving services. If you have a dispute that cannot be resolved, please contact the Privacy Officer, Dr. David Norton or his designee, at 630/377-6613. You may also file a complaint with the Office for Civil Rights, U.S. Dept of Health & Human Services, 200 Independence Ave; S.W., Room 509F, HHH Building, Washington, DC 20201. There can be no retaliation for filing a complaint.

**Consent to Treatment Form**

I consent to take part in the treatment at Centennial Counseling Center (CCC). I have received and read the **Intake Information** form explaining the risks and benefits of treatment, the fees for services, and other policies, and agree to its terms.

I have received and read 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 Intake Information or Privacy Notice that I do not understand.

I understand that **I am responsible for my bill**. While CCC will assist me in pursuing insurance or EAP reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency. I understand that CCC may elect to end treatment if timely payment for services is not made.

I understand that I will be charged \$125 for failing to show or for failing to give at least **24 hours' notice when canceling an appointment**. I understand that insurance companies and EAPs cannot be billed for this fee and therefore this fee will be my responsibility.

If I am electing to use my insurance or EAP benefits, I authorize release of the necessary information to my insurance company or EAP so that CCC, acting as my agent, may pursue payment for the services provided to me. I authorize insurance or EAP payments to be sent directly to CCC.

\_\_\_\_\_  
Client Signature (Parent signs for clients under the age of 12 years old) Date

\_\_\_\_\_  
If the client is between 12 and 18 yrs old, client and parent/guardian signature required Date

\_\_\_\_\_  
Other Family Member Date

Would you like to receive our quarterly newsletter highlighting various mental health issues? This mailing list will NOT be used for any other purpose.  Yes  
 No

CCC has my permission to keep the **credit/debit card** below on file.

Card number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on the card \_\_\_\_\_

Signature \_\_\_\_\_

**Notification of Desirability of  
Conferring with Primary Care Physician**

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 mental health services. We believe that it is desirable for us to confer and work together with your primary care physician on your care. Please indicate your desire 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 mental health services. In addition to this form, I am signing the attached Authorization to Release Information permitting Centennial Counseling Center to communicate with my physician.
  
- I waive** notification to my Primary Care Physician that I am seeking or receiving mental health services, and I direct you not to notify him/her.
  
- 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 mental health services.

\_\_\_\_\_  
Primary Care Physician

\_\_\_\_\_  
Physician's Address

1120 E. Main St.  
Cedar Crossing Building  
St. Charles, IL 60174  
630.377.6613  
Fax 630.377.6225

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

1 E. County Line Road  
Arrowhead Professional  
Building  
Sandwich, IL 60548  
815.786.8606  
Fax 815.786.1541

\_\_\_\_\_  
Therapist's Signature & Credentials

\_\_\_\_\_  
Date

110 East Countryside  
Parkway  
Yorkville, IL 60560  
630.553.1600  
Fax 630.553.7993

Notification Sent to Physician on \_\_\_\_\_  
Date