



CLIENT INFORMATION

Patient Name: _____
 Street Address: _____
 City, State, Zip: _____
 Date of Birth: _____ SSN: _____
 Gender: _____ Marital Status: _____
 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: _____
 Please send the quarterly e-mail newsletter to: _____
 and also to: _____

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: _____

 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 #: _____

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

207 E. Church St.,
 Suite A
 John Wentworth
 Business Center
 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.

Area of Concern	Never	Several Days	More than half the days	Nearly every day	Area of Concern	Never	Several Days	More than half the days	Nearly every day
Absences from school/work					Thinking about death				
Addictions					Thinking about suicide				
Aggression					Hopelessness				
Agitation					Loss of interest in activities/relationships				
Alcohol Use					Memory loss				
Anger					Mood changes (sudden)				
Anxiety					Muscle tension				
Blackouts					Nightmares				
Chest pains					Panic				
Compulsive behaviors					Perfectionism				
Concentration difficulties					Physical abuse (past/current)				
Conflict at work/school/home					Poor or no appetite				
Crying excessively					Pornography				
Overly distracted					Problems at home				
Feeling down and/or sad					Problems falling asleep				
Illicit drug use					Problems staying asleep				
Low energy					Problems with family members				
Too much energy					Racing/intrusive thoughts				
Fatigue					Restlessness				
Fear of leaving home					Poor self-confidence				
Feeling anxious and/or panicky					Self injury				
Feelings of guilt					Sexual abuse (past/current)				
Feeling jealous					Sexual dysfunction				
Feeling worthless					Sexual orientation				
Food and/or body preoccupation					Shortness of breath				
Gastrointestinal issues					Sleeping too much/too little				
Gender identity/confusion					Stealing behavior				
Grief/Loss					Easily startled				
Hearing voices					Struggles with social interactions				
Rapid heartbeat					Tobacco Use – cig/e-cig/vaping?				
Hallucinations					Under eating/restricting food				
History of trauma					Vomiting				
Irritability					Weight loss/gain				

Please let us know if there are other concerns you would like to discuss with your therapist:

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 45–60 minutes in duration, based on service provided. *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: \$185.00 Ongoing sessions range between: \$130.00 to \$185.00 (*based on service provided*)
Late cancellations/no-show: \$130.00

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 workstations and every effort is made to prevent others from viewing your personal health information. 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. Emails that include clinical information may be included as part of the 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. 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.

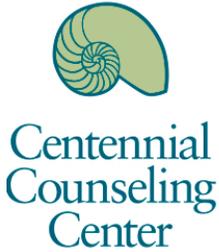
Additional rights.

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.

Credit Card Authorization



I hereby authorize Centennial Counseling Center to keep my credit card on file and use for payment of balances owed to Centennial.

Cardholder Name: _____

Billing Address: _____

Credit Card Type: ___ Visa ___ MasterCard ___ Discover ___ AmEx

Card Card Number: _____

Expiration Date: _____

CVV Security Code: (3-digit code on back of card) _____

Signed: _____

Dated: _____

Printed Name: _____

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

This authorization can be revoked at any time.

207 E. Church St.,
Suite A
John Wentworth
Business Center
Sandwich, IL 60548
815.786.8606
Fax 815.786.1541

110 E. Countryside
Parkway
Yorkville, IL 60560
630.553.1600
Fax 630.553.7993