



COMPASSIONATE
PSYCHOLOGICAL
CARE, LLP

Intake Information

_____		_____	
Last Name of Client		First Name of Client	
_____		_____	_____
Street Address		City	State Zip
_____	_____	_____	
Home Phone Number	Cell Number	Business Number	
_____	_____	_____	
DOB	Social Security Number (*optional)		
_____	_____		
E-mail			

Insurance Information

_____		_____		_____
Last Name of Insured		First Name of Insured		Relationship to client
_____		_____		
DOB	Social Security Number			
_____		_____		
Insurance ID Number:		Group Number:		

Place of Employment of Insured				

Name and Phone Number of Insurer				



Informed Consent for Treatment

Thank you for choosing **Compassionate Psychological Care, LLP**. Today's appointment will take approximately 50-60 minutes. We realize that beginning psychological treatment is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

Genevieve Nehrt, PsyD is a licensed clinical psychologist. She completed her undergraduate work at Illinois Wesleyan University, achieving a degree in Neuropsychology. Dr. Nehrt earned her masters in counseling from the Adler School of Professional Psychology, Where she went on to earn her doctorate degree. Dr. Nehrt specializes in child adolescent psychology, marriage and family psychology, and has a certificate in substance-abuse counseling. Additionally, Dr. Nehrt provides psychological evaluations for IQ, ADHD, learning disabilities, depression, anxiety, and other mental health issues.

Confidentiality and the Limits of Confidentiality

Your verbal communication with our providers, and any clinical records are strictly confidential except in the following contexts:

- a) Information (diagnosis and dates of service) shared with your insurance company to process insurance claims.
- b) A Release of Information (ROI) has been signed allowing specific information to be shared with external providers and/or other parties.
- c) Information you and/or your child/ children report about physical or sexual abuse. Please be aware that our providers are mandated reporters and according to Illinois State Law, all providers are obligated to report these instances to the IL Department of Children and Family Services).
- d) If you provide information to your provider that indicates that in danger of causing serious harm to yourself and/or others.
- e) Information necessary for case supervision or consultation.
- f) In any circumstance that is required by law.

Signature(s): _____

Date _____

Privacy Practice and Client Rights:

I affirm that I have been provided with, and have read, a copy of the Notice of Privacy Practices and Client Rights document.

Signature(s): _____

Date _____



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Contacting in the event of an Emergency

If you need to contact me, leave a message at **(224) 634-4160** and your call will be returned within 24 business hours. If an emergency situation, for which the client and/or their guardian feels immediate attention is necessary, and I am unable to return a call within 15 minutes, the client and/or guardian understands that they are to contact emergency services in the community by calling 911, or report immediately to the nearest Hospital Emergency Room for evaluation. In addition, if you need assistance with a crisis at any time, you may call the 24-hour crisis hotline at 1-800-248-7475 to speak with a trained counselor.

Signature(s): _____

Date _____

Financial Terms and Fee Schedule

As a courtesy we will bill your insurance company, HMO, responsible party, or third party payer for you if you wish. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. You will be responsible for any applicable deductibles, co-insurances amounts, and co-pays. Co-pays are to be paid at the time of your appointment. If insurance does not pay for services, you will be responsible for full payment of fees. The fee schedule for services is as follows:

Diagnostic Assessment (50-60 min.)	\$325
Individual Psychotherapy (50-60 min.)	\$250
Individual Psychotherapy (75-90 min.)	\$300
Couples/Marital Counseling (50-60 min.)	\$275
Couples/Marital Counseling (75-90 min.)	\$350
Group Psychotherapy (Per Session)	\$100

The above fee schedule may be altered if a sliding-scale fee schedule has been established at your therapist's discretion. Please consult with your therapist for more information.

Signature(s): _____

Date _____

Policy regarding Late Cancellation of Appointments

It is your responsibility to keep your scheduled appointments. If you must reschedule your appointment, please make every effort to contact me ahead of time, preferably at least three days in advance. *Please note that if you cancel your appointment with less than 24 hours of notice, or fail to show for your scheduled appointment entirely, you will be charged the full fee for the missed appointment.*

Signature(s): _____

Date _____



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Consent for Treatment

I authorize and request that **Genevieve Nehrt, PsyD** carry out mental health examinations, treatments, and/or diagnostic procedures, which now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may be at times difficult and uncomfortable.

Signature: _____ **Date** _____

Printed Name: _____

Consent for Treatment of Children/Adolescents

I consent that my child _____ may be treated as a client by **Genevieve Nehrt, PsyD**. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

Signature: _____ **Date** _____

Printed Name: _____

Relationship to client: _____



HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

All information describing your mental health treatment and related health care services (“mental health information”) is personal, and we are committed to protecting the privacy of the personal and mental health information you disclose to us. We are required by law to maintain the confidentiality of information that identifies you and the care you receive. When we disclose information to other persons and companies to perform services for us, we require them to protect your privacy, too. This Notice applies to your counselor, psychotherapist, psychiatrist and other health care professionals who provide care to you. We must also provide certain protections for information related to your medical diagnosis and treatment, including HIV/AIDS, and information about alcohol and other substance abuse. We are required to give you this Notice about our privacy practices, your rights, and our legal responsibilities.

WE MAY USE AND DISCLOSE YOUR MENTAL HEALTH INFORMATION:

- For **TREATMENT** we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.
- For **PAYMENT** we may contact your insurer to verify what benefits you are eligible for, to obtain prior authorization, and to receive payment from your insurance carrier.
- For **APPOINTMENTS AND SERVICES** to remind you of an appointment, or tell you about treatment alternatives or health related benefits or services.
- **WITH YOUR WRITTEN AUTHORIZATION** we may use or disclose mental health information for purposes not described in this Notice only with your written authorization

WE MAY USE YOUR MENTAL HEALTH INFORMATION FOR OTHER PURPOSES WITHOUT YOUR WRITTEN AUTHORIZATION:

- As **REQUIRED BY LAW** when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.
- For **HEALTH OVERSIGHT ACTIVITIES** to governmental, licensing, auditing, and accrediting agencies as authorized or required by law including audits; civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.
- In **JUDICIAL PROCEEDINGS** in response to court/administrative orders, subpoenas, discovery requests or other legal process.
- To **PUBLIC HEALTH AUTHORITIES** to prevent or control communicable disease, injury or disability, or ensure the safety of drugs and medical devices.
- To **LAW ENFORCEMENT** for example, to assist in an involuntary hospitalization process.
- To **THE STATE LEGISLATIVE SENATE OR ASSEMBLY RULES COMMITTEES** for legislative investigations.
- For **RESEARCH PURPOSES** subject to a special review process and the confidentiality requirements of state and federal law.
- To **PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY** of an individual. We may notify the person, notify someone who could prevent the harm, or notify law enforcement officials.
- To **PROTECT CERTAIN ELECTIVE OFFICERS** including the President, by notifying law enforcement officers of potential harm.



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HIPAA Statement of Client Rights

Right to request how we contact you

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

May we contact you at home? **Yes / No** **Phone Number:** _____
May we contact you at work? **Yes / No** **Phone Number:** _____
May we contact you by cell phone? **Yes / No** **Phone Number:** _____

Right to release your medical records

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization

Right to inspect and copy your medical and billing records.

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records.

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures.

You may request an accounting of any disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2003, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

Right to request restrictions on uses and disclosures of your health information.

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such a request.

Right to complain.

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services. An individual will not be retaliated against for filing such a complaint.

Right to receive changes in policy.

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.



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Authorization for Automatic Credit Card Payment

Patient Name: _____

For your convenience, and to guarantee payment for services rendered, we request documentation of a major credit card.

I authorize Compassionate Psychological Care, LLP to keep my credit card information and signature on file, and to charge my credit card account listed below for co-pays/co-insurance not collected at the time of services, and for any current outstanding account balances over 30 days following insurance determination, including fees due to late cancellation or not attending scheduled appointments.

I understand that this authorization is valid until I cancel the authorization through written notice to the health care provider or unless otherwise indicated.

Please note that charge dates may not coincide with session dates. Statements may be provided at your request.

Visa MasterCard Discover Card

Credit Card Number: _____

Expiration Date: _____

3-Digit Security Code: _____

Card Member Name: _____

Card Member Billing Address: _____

City: _____ State: _____ Zip: _____

Card Member Signature: _____ Date: _____



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Brief Physical Health History

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name (<i>Last, First, M.I.</i>):	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status:	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Previous or referring doctor:	Date of last physical exam:	

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

[Type text]

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea <input type="checkbox"/> Cola
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No	