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 _____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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.

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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.

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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 not 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:_____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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.

Christeen Noonan, LCPC, CADC is a Licensed Clinical Professional Counselor within the State of Illinois and a Certified Alcohol and Drug Counselor (certification conferred by Illinois Alcohol and Other Drug Abuse Professional Certification Association, Inc.). She received her Master's degree in Community Counseling from Argosy University and has clinical experience providing individual and family therapy to adolescents and adults, and families. Other treatment approaches may be used depending on the individual or condition being treated. Treatment practices, philosophy and plan limitations and risks will be discussed with you today.

For children and adolescent clients both parents must sign the informed consent unless one parent is deceased, one parent is incarcerated, or there is danger posed to the primary guardian and/or the child by the other parent being contacted. If parents of a minor client reside in the same household, both parents still must sign the consent form. If parents of a minor client do not reside in the same household, both signatures are required; and if there is a divorce decree, parenting or custody agreement – a copy must be provided to the clinician prior to the first session.

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**_____

Signature(s): _____ **Date**_____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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**_____

Signature(s): _____ **Date**_____

Contacting in the event of an Emergency

If you need to contact me, leave a message at **(312) 715-7614** 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**_____

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.

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

Fees for non-therapeutic services:
Written Letters – There is a fee of $100 for the first page and $50 for any additional pages.
Attendance at IEP/504 or other meetings: If Christeen Noonan, LCPC, CADC. is attending a meeting on the phone there is a charge of $50 for 30minutes. If she participates for under 30minutes, there will be no fee associated with her attendance of the meeting. If she is required to attend the meetings in person, there is a fee of $50 for every thirty minutes that is accrued from the time that she leaves her office to the time that she returns to her office.

Signature(s): _____ **Date**_____

Signature(s): _____ **Date**_____

Fees For Psychological Evaluations

Diagnostic evaluations that involve psychological testing range in price according to the number of testing hours needed to complete the evaluation. Testing hours include: administration time, scoring of materials, interpretation of findings, and integration of results into a written report. The number of testing hours per evaluations varies greatly depending on the presenting concerns and specific tests needed to adequately assess these concerns. An estimation of fees will be provided prior to the beginning of the assessment process.
The fee schedule for services is as follows:

Diagnostic Assessment (50-60 min.)	$325
Psychological Testing (per 60 min.)	$250
Comprehensive Psychological Report	$800
Explanation of Results	$275

I understand and agree that psychological testing may not be covered, or not covered fully by my insurance carrier. If you or your child are here for psychological testing, please be aware that pre-authorization does not guarantee payment or payment in full by your insurance carrier, or other third party payor. By signing below, you are agreeing to be responsible for fees incurred for these services, if your insurance denies payment and/or revokes, reduces the units of your pre-authorization or it is not a covered service.

Signature(s): _____ **Date**_____

Signature(s): _____ **Date**_____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

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. **Charge for Late cancelation is $125.00.** *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**_____

Signature(s): _____ **Date**_____

I understand that Christeen Noonan, LCPC, CADC will not testify or otherwise get involved with attorneys during a civil litigation or other legal or administrative proceedings. By signing below I agree not to subpoena or ask Christeen Noonan, LCPC, CADC. to testify in a legal proceeding brought by or against me, either during the therapeutic relationship or thereafter.

Signature(s): _____ **Date**_____

Signature(s): _____ **Date**_____

If I require Christeen Noonan, LCPC, CADC. to attend court or subpoena her in a court proceeding, our current therapeutic relationship will be terminated after thirty days. Whatever time is required by Christeen Noonan, LCPC CADC. to complete paperwork for the court, speak with lawyers or other court officers, travel to court, participate in court proceedings, and return to her office will be met with a fee of $150 per hour of her time spent in these activities. I accept responsibility for these fees if I require these services from Christeen Noonan, LCPC, CADC.

Signature(s): _____ **Date**_____

Signature(s): _____ **Date**_____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

Consent for Treatment

I authorize and request that **Christeen Noonan, LCPC, CADC** 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: _____

Signature: _____ **Date**_____

Printed Name: _____

Consent for Treatment of Children/Adolescents

I consent that my child _____ may be treated as a client by **Christeen Noonan, LCPC, CADC**. 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:_____

Signature: _____ **Date**_____

Printed Name: _____

Relationship to client:_____

COMPASSIONATE PSYCHOLOGICAL CARE, LLP

Brief Physical Health History

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

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ 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

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ 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?				☐ Yes	☐ No
					☐ Yes	☐ No