**New Patient Intake Form**

Welcome, and thank you for choosing Broadreach Counseling LLC. Please fill out the following information to the best of your ability.

**Basic Information:**

Name of Patient: Date of 1st Session:

Date of Birth: Age:Gender ID:Partner Status:

House/Street Address

City State Zip

Cell Home Work

Email

**Name of Parents/Guardians** (if patient is a minor) (also list people that may drop off/pick up):

 Relationship: Phone:

 Relationship: Phone:

 Relationship: Phone:

**Occupation**: **Current Employer**:

**Student: Full Time Part Time NA**

**Emergency Contact Name**: Phone:

**Emergency Contact Name**: Phone:

**Referred by:**

**Reasons for seeking therapy** (check all that apply; answer to the best your ability or leave blank if you cannot answer at this time):

|  |  |  |
| --- | --- | --- |
| * Depression/sadness
 | * Psychosis
 | * Relationship issues
 |
| * Anxiety/worry
 | * Obsessions/compulsions
 | * Social skills
 |
| * Anger/irritability
 | * Inattentiveness
 | * Sexuality
 |
| * Trauma/stress
 | * Hyperactivity
 | * Grief/loss
 |
| * Divorce/separation
 | * Substance use:
 |  |

**Have you previously been diagnosed with a mental illness?** (Y or N) List:

**Medical conditions or allergies or we need to know about:**

**Current medications:**

**Informed Consent for Treatment**

Patient Name (print):

Patients Date of Birth:

Name of Parent/Guardian (print):

Relationship to Patient (i.e. mother, grandparent, etc.):

**Informed consent to provide treatment:**

This Consent Form authorizes Broadreach Counseling LLC to provide treatment and services for the above-mentioned patient.

I acknowledge that no guarantees have been made regarding the outcome of treatment provided by the therapists at Broadreach Counseling LLC. I have read this form and certify that I understand its contents. I hereby give consent to Broadreach Counseling LLC to treat myself/child.

Signature of Patient: Date:

Signature of Parent/Guardian: Date:

Signature of Witness: Date:

Please list the name and contact information for other physicians, providers or persons you give permission to exchange information with Broadreach Counseling LLC (if none, leave blank):

Name: Contact Info:

Name: Contact Info:

Name: Contact Info:

**Insurance Information Form**

Broadreach Counseling LLC will bill the insurance company listed below once verification has been received. **Please note**: We only accept PPO plans and the specific Medicaid plans listed. We do not accept HMOs (with the exception of BCBS HMO Advocate).

**Patient Information**

Name of Patient:

Name of Insured (if different than patient name):

Patient date of birth:

**Insurance Information** (check all that apply)

* Blue Cross Blue Shield PPO
* Blue Cross Blue Shield HMO (Advocate Health)
* Aetna BehavioralHealth
* Aetna BetterHealth
* Humana
* Cigna
* United/Optum
* Magellan
* Meridian
* Illinicare
* Medicare
* Other:
* None

Primary Insurance

Group/Policy #

Member/ID #

Insurance’s Phone #:

If you use second insurance carrier (supplemental) please list below:

Secondary/Supplemental Insurance

Insurance Carrier:

Group/Policy #

Member /ID #

Insurance’s Phone #:

**Payment Policy Form**

**Payment Policy**

Payments are collected at the end of each session. If a credit/debit card is on file with us, the card will be charged after the session, before the end of the appointment day. The card on file will also be charged on the same day of a missed session or late cancellation (see Cancellation Policy below).

**Cancellation Policy**

We require 24-hour notice for cancellations. If you cancel less than 24 hours prior to a session, you will be responsible for the cost of the session (emergency situations will be taken into consideration). The same policy applies for missing scheduled sessions. In these cases, the credit/debit card on file with Broadreach Counseling LLC will be charged on the day of the late cancellation or missed session.

**Please note**: insurance does not cover missed appointments. You will be charged $80 (half of the standard fee) if you do not give 24 hours notice.

**Clients Covered by Insurance**

Each insurance carrier determines which services are covered, how many sessions are allowed, and who are approved as providers of the service. We will work with you to maximize your coverage. You are expected to pay your copayments or your coinsurance percentage at

the time of service. If we are in network, we will discount our standard charge based on the contracts we have with your insurance carrier. If you have a deductible, this will be

billed to you as it becomes known. You will be responsible for any expenses not covered by your insurance. This includes any deductibles, payments, copayments or coinsurance, and all noncovered services, as defined by the insurer.

**Fill out the below section with your therapist during the first session**

**Select reason for collecting payment**:

* Co-payment/co-insurance
* Payment towards insurance’s deductible
* Private pay
* Sliding fee agreement

**Sliding Fee Scale**: (discussed and agreed upon between patient and therapist)

* $50/session. Household/family income of less than $25,000 per person
* $75/session. Household/family income of less than $40,000 per person
* $100/session. Household/family income of less than $60,000 per person

**Sliding fee amount per session**: $

**Payment Policy Form**

My signature indicates that I have read this form and understand the payment collection policy and cancellation policy of Broadreach Counseling LLC. Please read and complete with your therapist by the end of the first session.

Printed Name of Patient/Guardian:

Signature of Patient/Guardian: Date:

Printed Name of Therapist:

Signature of Therapist: Date:

**Clients Right and Responsibilities**

Clients have the right to:

* Receive quality services in a respectful manner without discrimination
* Make an informed choice of services
* Know the qualifications of staff who provide them with services
* Receive and understand information and instructions about their service needs
* Consent to or refuse services before they are provided
* Know the nature and purpose of services
* Be informed prior to any transfer or discharge from services
* Expect confidentiality of information and protection of records
* Receive timely response to their needs along with reasonable continuity and coordination of services
* Know about charges for services
* Know how to voice any grievance about their services
* Receive services based on an individual treatment plan
* Be part of the process of updating the treatment plan when his or her needs change

Clients have the responsibility to:

* Give accurate information about their mental health, substance use, and domestic violence issues
* Assist by making and keeping a safe environment
* Notify the therapist if scheduled appointments need to be changed
* Inform the therapist immediately if there are any problems or concerns with the treatment being provided
* Accept financial responsibility for services
* If insurance coverages changes to notify the therapist immediately of the change

Sign below to indicate you have received, reviewed and understand the above information:

Name of Patient

Signature of Patient/Guardian Date

**Notice of Privacy Practices/HIPAA Guidelines**

This notice explains how the health information of Broadreach Counseling LLC is used or disclosed. Please review, sign and date at the end of the form.

**Use and Disclosure of Protected Health Information**

***For Treatment***

**Under Illinois law, we are not allowed to release your information, except in emergency situations, without your consent**. Information will not automatically be disclosed even physicians/providers, places of employment, or family members. Exceptions to this law include emergency situations involving potential harm to yourself or someone else whereas we would only contact someone able to help prevent the threat. In the case your information needs to be released or exchanged, we will discuss this with you and request your written consent to do so. Your consent can be withdrawn at any time.

For minors under the age of 12, a parent, guardian or power of attorney may authorize the release of information. For those 12 or older, they will be informed and they have the right to refuse the release of their information. In this case, information will not be released.

Additionally, a minor’s therapist may find reasons for denying access to or the release of information. These reasons include decisions solely with the best interest of the client as basis for the decision and/or in a scenario compromising the therapeutic relationship with the minor.

***For payment***

We may use or disclose your information so that treatment and services may be billed to your insurance company or a third party (i.e. credit/debit card company). Broadreach Counselling LLC will ask your permission and for written consent before we do so.

***As Required by Law***

We may disclose your health information if court ordered. Your health information is not subject to subpoena with a court order. However, all providers at Broadreach counseling LLC are mandated reporters and are required by law to report suspected abuse and neglect of children and the elderly. We are required to warn and protect when we believe there to be immediate danger, including domestic violence. This may involve contacting police, law enforcement, or an abuse investigatory agency like the Illinois Department of Child and Family Services (DCFS). However, past criminal behavior shared in therapy is protected by confidentiality and will not be disclosed without your written permission. If a crime is committed on our premises we have the right to share necessary information with the authorities to aid in their investigation or apprehension.

**Notice of Privacy Practices/HIPAA Guidelines**

***Health Oversight and Specialized Government Functions***

We may be required to disclose information in activities of auditing, investigations, or inspection of clinical records by health oversight organizations like Medicare or licensure boards.

***Coroners or Medical Examiners***

We may release information as necessary in the event of a death of a patient to help with determining identity or cause of death.

***Your Rights to Your Health Information***

You have the right to inspect and copy your clinical record. However, we may request that you review your record with your therapist. You may also request a copy of your clinical record, at a reasonable fee for copying, time of service, and postage. The original copy of clinical record is property of Broadreach Counseling LLC and is never released.

If you believe something in your clinical record to be incomplete or incorrect, you have the right to request we amend it. This request must be done with your therapist and they may choose to deny your request without sufficient reason to amend. We are not obligated to amend all requests but will give each careful consideration. If denied, you may file a statement describing your request for amendment and your objections which will then be attached to your clinical record.

**Questions or complaints** regarding these policies or laws can be addressed to your therapist by phone or written mail via the contact information listed below:

Kyle Parmelee, MSW, LCSW

Phone: 847-348-9898

Katherine Henoch, MA, LCPC

Phone: 847-348-9501

1580 S. Milwaukee Ave., Suite 104

Libertyville, IL 60048-3705

**Notice of Privacy Practices/HIPAA Guidelines**

We will never retaliate against persons filing complaints against our agency or its providers. If you feel Broadreach Counseling LLC has violated any of your privacy rights, you can contact one of the overseeing authorities below:

U.S. Department of Health and Human Services

Office of Civil Rights

312-886-2359

Illinois Human Rights Authority

North Suburban Regional Authority

866-274-8023

Illinois Guardianship & Advocacy Commission

312-793-5900 or 312-793-5397 (TDD)

Illinois Department OF Human Rights

312-814-6200 or 217-785-5125 (TDD)

Sign below to indicate you have received, reviewed and understand the above information

Signature of Patient: Date

Signature of Parent/Guardian: Date

Signature of Therapist: Date

**Credit/Debit Card Authorization Form**

Broadreach Counseling LLC requires that a credit or debit card be kept on file as a convenience for charging co-payments, fees, etc. The card on file will also be used in the case of missed appointments and late cancellations. The card will remain on file until the end of treatment when the card information will be destroyed.

Please select a credit or debit card to keep on file with Broadreach Counseling LLC and sign below authorizing use of this card to charge for services provided.

**Credit/debit Card Type:** (select one)

* American Express
* Discover
* MasterCard
* Visa
* Other:

Name of Card Holder:

Card Number:

Expiration Date (mm/yy):

Security Code (3-digit number on back of card) (4-digit for American Express):

Billing Address of Card Holder:

House/Street Address

City State Zip

Signature of Card Holder: Date: