dynamic fusion
COUNSELING
& CONSULTING

Counseling Services Intake - Informed Consent, Privacy & Rights

Client Name:_____ Date: _____

Welcome

Welcome, it takes courage to reach out for support and I look forward to supporting your healing journey. These forms contain information about Dynamic Fusion Counseling & Consultants, (or DFCC) professional counseling services and business policies. There are also several questions included that will help better identify what challenges you are currently facing so that I can best assist you. It is important that you review the following information before beginning your first session. Please feel free to ask any questions you may have about these policies; I will be happy to discuss them with you. There are various places where your signature is required on the following forms; please bring these **completed** forms with you to your first session.

Privacy & Rights

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.

Availability of Your Therapist:

I try to return calls promptly, but at times may be unable to return calls as soon as you may require. In the event that I am unavailable in an emergency, go to the nearest local emergency room or contact the following crisis intervention service: 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 beginning of the session. At this time, I accept cash, checks and credit card. If payment is not made at the time of service, I ask you to settle the bill prior to the next session. Appointments are generally 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 me by text, phone or email 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.***

Late cancellations/no-show: the full fee for the session: $135.00.

(Insurance will not pay for late cancellations or no-shows; these would be your responsibility.)

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, I have 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 me. 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.** I recommend that you verify your coverage prior to or within 24 hours of the first appointment to be sure that and these services will be covered for an out-of-network mental health care provider.

Other Fees:

There is a $60 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 me.

Court issues:

Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are seeing me, I may then be ordered to show the court my records. Testifying in court is beyond my scope of practice. It is my policy to **not** go to court for clients. If your purpose in seeing me is to have a counselor appear in court on your behalf, please be advised that you should see a counselor who specializes in this area instead. Please consult your lawyer about these issues.

Other Points:

If you ever become involved in a divorce or custody dispute, I want you to understand and agree that I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. This position is based on two reasons: (1) My statements will be seen as biased in your favor because we have a therapy relationship; and (2) the testimony might affect our therapy relationship, and I must put this relationship first.

PRIVACY NOTICE

I am committed to treating and using protected health information responsibly. This Notice describe the procedures I 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.* I strongly suggest you review these provisions in order to fully understand our procedures and your rights.

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.

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 under18 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. I am happy to provide you with assistance in understanding the record.

In the following circumstances, I 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 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, I am not require to agree to a requested restriction, and in some situations, am 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. I reserve 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.

Consent to Treatment Form

I consent to take part in the treatment with Erica Sokol, LCPC, NCC. 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**. 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 Erica Sokol, LCPC, NCC may elect to end treatment if timely payment for services is not made.

I understand that I will be charged the full session fee 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 benefits, I authorize release of the necessary information to my insurance company so that Erica Sokol, LCPC, NCC, acting as my agent, may pursue payment for the services provided to me. I authorize insurance payments to be sent directly to Erica Sokol, LCPC, NCC.

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

X_____Date_____

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

_____Date_____

Other Family Member

_____ Date_____

Other Family Member

_____ Date_____

Dynamic Fusion Counseling & Consultants

815-401-6241 • www.mynapervillecounselor.com • 710 E. Ogden Ave Suite 645 • Naperville, IL 60540

CLIENT INFORMATION		
Full Name: Name that you like to be called (nickname):		
Home Address w/zip code: Ok to mail to this address? □ Yes □ No		
Date of Birth:	Sex: □ M □ F	Relationship Status: □ S □ M □ D □ Sep □ W
Emergency Contact Information - In the event of an emergency, please provide a contact person: Name:_____ Relationship:_____ Phone:_____		
Occupation:	Position:	
Employer/Company Name:		
Email: (used for appointment reminders and rescheduling) Ok to email? □ Yes □ No (Please note that email correspondence is not guaranteed to be confidential)		
Home Phone#:	Cell Phone#:	Text: (Please note that text correspondence is not guaranteed to be confidential)
Ok to leave messages? □ Yes □ No	Ok to leave messages? □ Yes □ No	Ok to text? □ Yes □ No
Have you previously attended therapy? □ Yes □ No What kind of therapy? Inpatient /Outpatient/ Other: _____	If yes, what was the length of treatment, and last date attended? Length: Date(s):	If yes, why did you stop attending therapy?

BIOPSYCHOSOCIAL HISTORY			
Symptoms and Behaviors (Please be as specific as possible to any 'yes' responses)			
Mania/manic symptoms	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Depressed Mood	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Appetite Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Sleep Disturbances	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Change in Energy Level	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Decreased Concentration	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High

Worthless/Helpless Feelings	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Anxiety Symptoms/ Panic Attacks	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Bingeing/Purging	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Feelings of Guilt	□Yes	□ No	If "Yes", circle severity: Low ←1 2 3 4 5 6 7 8 9 10 →High
Obsessions/ Compulsions	□Yes	□ No	If "Yes", please describe:
Phobias	□Yes	□ No	If "Yes", please describe:
Medical Conditions	□Yes	□ No	If "Yes", please describe:
Hyperactivity	□Yes	□ No	If "Yes", please describe:
Are you having suicidal thoughts?	□Yes	□ No	If "Yes", do you have a plan about how you would commit suicide:
Do you have the means to carry out your plan?	□Yes	□ No	If "Yes", how would you do this?
Have you ever made a suicide attempt or been hospitalized for suicide?	□Yes	□ No	Describe: Date(s) of attempt(s):
Is there a history of suicide in your family of origin?	□Yes	□ No	If "Yes", please list who and what year:
Have you had a previous diagnosis by a counselor or psychiatrist?	□Yes	□ No	If yes, please list the diagnosis's and the years:

Prescription Medications (please list all currently taking or have taken, the length of time and what they are prescribed for: pain, illness, depression, etc.)

1.
2.
3.
4.

List anything other medications or comments that your counselor should be aware of regarding your physical or mental health:

Substance Use

Are you currently using alcohol, nicotine or other prescription or non-prescription drugs? Please list how much and how often you drink and/or take prescription or non-prescription drugs:	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever felt you would like to cut down on your substance use?	□Yes	□ No
Have you ever been arrested for a DUI, or drug use? Or do you have a past that involves using drugs or alcohol. Please briefly describe circumstances below:	□Yes	□ No

Family & Relationship History (Use reverse side of this page if you need additional space)

	Age	Name	Living With You (Y/N)	Deceased (Y/N)
Spouse/Partner	_____	_____	____	____
Parent	_____	_____	____	____

Age		Name	Living With You (Y/N)	Deceased (Y/N)
Parent	_____	_____	____	____
Stepparent	_____	_____	____	____
Stepparent	_____	_____	____	____
Sibling	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
Children/Step	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____
	_____	_____	____	____

Are your parents divorced? □ Yes □ No Remarried? □ Yes □ No

Religion (if any) _____

Sexual orientation _____

Gender orientation_____ (female, male, transgender, transsexual)

Ethnic Group (select all that apply):
American Indian Alaskan Native Caucasian Middle Eastern
Asian Pacific Islander Hispanic/Latino Black/African American
Multi-Ethnic/Other_____

Family of Origin (Circle Your Answer)
Have you experienced any abuse in your family or relationships?
None Emotional Physical Sexual Uncertain
In general, how happy Ire you growing up?
None Somewhat Mostly Extremely
How much is your family of origin a source of support for you?
None Somewhat Very Extremely
How much conflict in values do you experience with your parents?
None Somewhat Substantial

Legal Issues
Have you personally experienced legal problems? □ No □ Yes (describe)

Are you currently involved in a lawsuit? If so please describe:

Dynamic Fusion Counseling & Consultants
815-401-6241 • www.mynapervillecounselor.com • 710 E. Ogden Ave Suite 645 • Naperville, IL 60540

Briefly describe concerns in your life and/or in your relationships that would be relevant for your counselor to know. You may use the back of the form for more space if needed:

On a scale of one to ten, how motivated are you to resolve this issue? _____

Please list your therapy goals (list as many that apply & use the back if need be):
1.

2.

3.

Thank you for taking time to read and complete these questions. This information will be helpful in your therapy process. Your signature is required on the last page before I can begin our work together. Please discuss any questions you may have with your counselor prior to signing.

- **I have thoroughly read and fully understand the Informed Consent and the therapy policy pages of this document.**
- **I understand that I am financially responsible for charges and fees incurred. And I agree to honor the 24 hour cancellation policy.**
- **I understand limits of confidentiality and all mandated reporting by my counselor.**
- **I understand that emailing, texting and cell phone are not guaranteed as confidential.**
- **I have answered all questions in full, truthfully and to the best of my knowledge.**
- **I have had all questions about this document answered and sign willingly.**
- **I authorize my counselor employed with Dynamic Fusion Counseling & Consultants to provide psychotherapeutic treatment for me, the client, signing below:**

Client's name (printed):_____

Client's signature:_____ Date: _____
(Parent signs for clients under the age of 12 years old)

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

_____ Date_____
Other Family Member

_____ Date_____
Other Family Member

Counselor's name (printed): _____

Counselor's signature: _____ Date: _____

Dynamic Fusion Counseling & Consultants

815-401-6241 • www.mynapervillecounselor.com • 710 E. Ogden Ave Suite 645 • Naperville, IL 60540