# INTAKE FORMS

Face Sheet

**This form is required for your file. The information is needed for claims and/or auditing purposes. Please fill in all areas. "Client" & "Patient" refer to person seeking services. "Member" refers to the person who carries the insurance policy.**

## Client information

**Client Name**
(Place use capital letters)

**Client Address** _____

**Primary Phone Number:** _____
Do we have permission to leave you a message at this number? ☐ ☐

**Secondary Phone Number:** _____
Do we have permission to leave you a message at this number? ☐ ☐

**Client´s Gender:** _____

**Client´s Marital Status:** _____

## Insurance Information *

(Do not complete if you are electing to self pay.)

**Member´s Name:** _____ **Member´s Employer:** _____

**Insurance Company:** _____ **Group:** _____

**Member ID** _____ **Member´s Date of Birth** ___/___/___

**Patient ID** _____ **Patient´s Date of Birth** ___/___/___

**Patient relationship to member:** ☐ **SELF** ☐ **SPOUSE** ☐ **CHILD / DEPENDENT**

## Plase look on the back of your insurance card for the following phone numbers:

**Member Services:** _____ **Behavioral/Mental Health:** _____

***Providing this information does not guarantee insurance payment. Client assumes full responsibility for services**

**Today´s Date** ___/___/___

## Were you referred to DKS Counseling LLC?

**INSURANCE:** _____

**INTERNET:** _____ _____

**OTHER:** _____

**Emergency Contact: (Name, Phone & Relation)**

_____

_____

_____

Session Fees & Copays: Due at the beginning of each appointment. Payment can be made by cash, check or credit card. **Checks should be made payable to DKS Counseling LLC.**

DKS COUNSELING

# CHOOSING YOUR PAY STATUS

Choosing to bill counseling sessions through your insurance carrier is an important decision you must make. According to federal regulations, you may choose to pay out-of-pocket and NOT bill through your insurance policy. If you so choose this you will be considered a Self Pay Client.

Should this be your preference, DKS Counseling LLC would NOT have the authorization to share your records with your insurance company. The decision you make at the outset of service may be reversed at any time by completing a new form and updating your file.

However, please note that rates you pay for services as a Self Pay Client may be higher than the rates you would pay if we were an in-network provider with your insurance company. Should you decide at a later date to submit bills to your insurance company, your rates for services would reflect the insurance-rate or Self Pay Client rate at the time services were provided according to your contract with DKS COUNSELING LLC.

***Please indicate your status below by checking off your preference***

☐ I choose to be designated as a "Self Pay Client" at DKS COUNSELING, LLC. I will pay for sessions out-of-pocket with cash, check, or credit card, in accordance with my signed contract for services.
I do not authorize DKS COUNSELING LLC, its agents or employees, to share my private information with my insurance company.

☐ **I would like to seek payment for services through my insurance company. I understand that** if DKS COUNSELING LLC is in network with my company, my rates will be the same as the contracted rate DKS Counseling LLC has with my insurance company. I will be responsible for any copays, coinsurance amounts, deductible payments, or any portion of the session fees not covered by my plan. I authorize this as of the date of my signature below.

**CLIENT / CLIENT REPRESENTATIVE´S SIGNATURE**

X

**DATE** ____/____/____

**DKS COUNSELING LLC REPRESENTATIVE´S SIGNATURE**

X

**DATE** ____/____/____

DKS
COUNSELING

# CONTRACT, OFFICE POLICIES AND FINANCIAL AGREEMENT

**DKS Counseling, LLC** is a business facility where a number of therapists engage in the practice of mental and behavioral health services delivery ("counseling").

**Rights and Risks:** Please feel free to ask questions about any aspect of the counseling process.
You need to be willing to discuss what troubles you are having, and be open to change.
You may remember unpleasant events, arouse intense emotions, and/or alter close relationships. The purpose of counseling is to facilitate your process.
If you have been referred by a court or state agency, you have the right to divulge only what you want included in a report.

**Confidentiality:** Information shared will be held in confidence with certain limitations.
Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
Your therapist is required by law to disclose information pertaining to suspected child or elder abuse or neglect; inability to care for one´s basic needs for food, clothing or shelter; and threatened harm to oneself or others.
The courts may in select cases subpoena counseling records.
It is understood that information regarding treatment and diagnosis will be provided to an insurance company ***if you opt to bill your insurance company for services.***
You may want to discuss further limits or exceptions of confidentiality.

**Privacy:** By signing this contract, I acknowledge receipt of the separate form Notice of Privacy Practices. I understand DKS Counseling utilizes a paper/file management system to maintain my records. I understand that my file is stored in a locked cabinet at the facility. I understand that any counseling session in which I participate with a co- therapist is for the purpose of improving my care, and not an invasion of my rights of privacy.

**Appointments:** All office visits are by appointment with your therapist directly. Please arrive on time, as you use up your own time when you arrive late for an appointment. The usual length of an appointment is 55 minutes.
***Late cancellations (less than 24 hours before) will result in a $100 fee.***
***No-show appointments are charged the full cost of a session to the credit card on file.*** If your appointment is canceled or missed, contact your therapist for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges.

**Fees:** Payments and co- payments for services are required at the time services are rendered.
Your health insurance may help you recover some of your counseling cost. Verify with your company the amounts of coverage for outpatient psychotherapy by licensed professionals.
Regardless of your intention to use insurance, the "Insurance Declaration Form" MUST be on file before service can commence.

By signing this contract, you acknowledge responsibility for payment per hour for any demand on the therapist´s time that occurs under your direction and/or on your behalf. This includes time demands that result from involvement in any legal proceeding. The fees are detailed on page 5.
"Self Pay Clients" as defined in our Insurance Declaration Form are expected to pay their fees at the time services are rendered. Our office will provide an "insurance ready" receipt upon request. Clients will receive a statement periodically reflecting any balance due on their account, either in paper copy or via email when we are granted permission to do so. This office will not accept responsibility for collecting insurance claims or for negotiating a settlement on a disputed claim. Clients and parents/ guardians of minor clients are responsible for payment (and insurance claims) on their accounts. Accounts become delinquent after (30) days.

**ACCEPTANCE OF TERMS:** ***Any change in my financial or insurance situation I will discuss with my therapist.*** I have read, understand and agree to the above policies and fee schedule on Page 2 of this contract. I have discussed these policies and understand a copy is available on the practice website. I hereby authorize DKS Counseling LLC and my therapist to abide by my expressed preferences on the Choose Your Status Form I submitted.
With this contract. I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment of charges incurred. I ***understand that in the event of non-payment,I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I understand that Co-pays and Deductibles are not negotiable.***

**Consent to Treatment and Fee:** I hereby agree to full responsibility for all expenses incurred by me and/ or on account of this client and hereby assign DKS Counseling LLC and Insurance benefits due to me to the full extent of my financial obligation to DKS Counseling LLC. I have read and/ or received a copy of Notice of Privacy Practice Policy. A completed Insurance Declaration Form is required for my file.

**FEE SCHEDULE**
I acknowledge and understand the fee schedule, detailed in the table below. I understand that the STANDARD portion of the fee schedule may be submitted to my insurance company for payment if I authorize DKS Counseling LLC to do so on my behalf. I understand and accept that I am responsible for copays and deductible amounts.

I**n the event that I cancel an appointment within 24-hours or fail to attend a scheduled appointment (NO SHOW), I hereby authorize DKS Counseling LLC to charge to my credit card the appropriate fee.**

I understand that the "ADDITIONAL" portion of the fee schedule is not billable to insurance and will not paid for by a third party. Any "ADDITIONAL" fees incurred by me or by my dependent child are my sole responsibility.

| STANDARD FEES | 53-60 minutes | Flat Fee |
|---|---|---|
| Initial Intake Assessment/ Interview | | $200 |
| Individual Counseling | $150 | |
| Marriage Counseling/Family | $110 | |

| ADDITIONAL FEES (to be paid by the undersigned) | |
|---|---|
| Cancel less than 24 hours | $100 |
| No Show Fee | Full cost of session |
| Phone Calls 5-15 minutes | $40 |
| Consultation with outside agencies/schools | $150 (up to 1 hour) |
| Depositions, subpoenas, legal and/or court proceedings | $300 (up to 1 hour) |
| Paperwork/Form completion/Letters | $40 |

**CLIENT SIGNATURE** X **DATE** ____/____/____

By providing your email address, you authorize DKS Counseling LLC to issue your invoices and statements via email. You may withdraw your consent at any time by providing a request in writing.

**Email Address:** _____ **Signature:** _____

# CREDIT CARD AUTHORIZATION FORM

We understand that things happen and sometimes you can´t appear for your scheduled appointment. In that case, please speak with your clinician and provide 24 hours notice. In the event of late- cancellation (less than 24 hours) or no-show, we will charge your credit card for the appropriate fee for the missed appointment. Thank you for your understanding. **NOTE:** There MAY BE a **3.5% processing fee** for all credit card transactions (Ask your therapist to confirm.)

Name: _____

Billing Street Address: _____

City: _____ State: _____ Zip Code: _____

**CLIENT SIGNATURE** X _____ **DATE** ____/____/____

_____ (Initials) I authorize DKS Counseling LLC to charge my credit card for co-pays/ co-insurance payments per session.

_____ (Initials) I authorize a late-cancellation charge, in the event that I cancel with less than 24 hour notice, against my credit card for the cost of $100.

_____ (Initials) I authorize a no-show charge, in the event that I do not call (no emails please) to cancel against my credit card for the full fee of the session.

**CREDIT CARD INFORMATION**

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover Card

Number: _____

Expiration Month: _____ Expiration year: _____

**CARDHOLDER SIGNATURE** X _____ **DATE** ____/____/____

**SECURITY CODE:_____**
**(3 digit code on back of card)**

**Zip Code associated with credit card:_____**

DKS
COUNSELING

# PRIVACY PRACTICES/ POLICIES

*We respect our clients´ confidentiality and only release information about you in accordance with state and federal laws.*

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes our policies related to the use of the records of your care at DKS Counseling LLC We are required to give you this Notice about (1) the use and disclosure of your health information. (2) our legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice. You may request a copy of this at any time. For more information about our privacy practices or for additional information, contact DKS Counseling LLC, Attn: Dane Snyder LCPC, CADC at, 1618 W. Colonial Parkway Inverness, IL 60067.

**1- USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

We use and disclose the minimum necessary health information about you for your treatment, for payment for services, and for DKS Counseling LLC, health care operations.
**a. For Treatment.** We use and disclose your health information internally in the course of your treatment at DKS Counseling LLC. For example, we may give information to another DKS Counseling LLC health care clinician for the purpose of referral within the practice. If you wish us to provide information outside of our practice for your treatment by another health care provider, we will have you sign an authorization to do so.
**b. For Payment.** We may use and disclose your health information to obtain payment for services we provide to you as delineated in the "Contract, Office Procedure, and Financial Agreement". We may need to give insurance companies or other agencies the minimum necessary information in order for them to pay us for the service we have provided to you.
**c. For Health Care Operations.** We may use and disclose your health information within DKS Counseling LLC as part of our internal health care operations. For example, this could mean a review of records to assure quality. We may also use your information to tell you about services, educational activities, and programs that we feel might be of interest to you.

**2- INFORMATION DISCLOSED WITHOUT YOUR CONSENT**

Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances.
**a. Emergencies.** Sufficient information may be shared to address an immediate emergency you are facing.
**b. Judicial and Administrative Proceedings.** We may disclose your personal information in the course of a judicial or administrative proceeding in response to a valid court or other lawful process.
**c. Public Health Activities.** If we felt you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

**d. Child / Elder Abuse.** We may disclose health information about you related to suspicion of child and/or elder abuse or neglect.
**e.** Criminal Activity or Danger to Others. We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.
**f. National Security, Intelligence Activities, and Protective Services to the President and Others.** We may release health information about you to authorized federal officials as authorized by law in order to protect a national or international figure, or in cases of national security.
**g. Health Oversight Activities.** We may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with their requirements. The minimum necessary information will be provided in these instances.
**h. Business Associates.** DKS Counseling LLC may disclose the minimum necessary health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services.
**i. Research/ Supervision.** Under certain circumstances, DKS Counseling LLC may use and disclose health information for supervision with provisionally licensed counselors/social workers/therapists.
**j. Scheduling Appointments**. DKS Counseling LLC may use your phone number to call you or text you and leave messages to schedule or remind you of appointments.

**3- YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:**

**a. Right to Inspect and Copy.** You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the ***information, a reasonable charge may be made for the costs incurred.***
**b. Right to Amend.** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We have the right to deny your request under certain circumstances.
**c. Right to an Accounting of Disclosures.** You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing. Such accountings are available for seven years after the last date of service at DKS Counseling LLC.
**d. Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you could ask that we not share information with an insurance company, in which case you would be responsible to pay in full for the services provided. To request a restriction after therapy is completed, you must make your written request to DKS Counseling LLC. We are not required to agree to your request, but we will consider the request very seriously. If we agree, we will abide by our agreement unless the information is needed in an emergency or by law.
**e. Right to Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every attempt to accommodate reasonable requests.

**f. Right to Obtain a Paper Copy of this Notice.** You have the right to receive a paper copy of this notice and any amended notice upon request. Copies are available at the office of DKS Counseling LLC or on our website: ***www.dks-counseling.com.*** Any other uses and disclosures not set out in the information above will be made only with your written authorization, and will become effective when it has been received by DKS Counseling LLC.

**I,** _____

**have received a copy of the Privacy Practice Notice,and it has been explained to me.**

**SIGNATURE**

X

**DATE** ____/____/____

**PARENT/ GUARDIAN SIGNATURE (if necessary)**

X

**DATE** ____/____/____

# AUTHORIZATION FOR RELEASE/ EXCHANGE OF INFORMATION

Authorization for the use and disclosures of Protected Health Information (PHI) is only for the person or agency on this form. Any duplication, transmittal, re-disclosure, or re-transfer of information is expressly prohibited.

I, _____, authorize DKS COUNSELING LLC whose main office is at 1618 W. Colonial Parkway Inverness, IL 60067 to release/ exchange by phone, fax, or email the PHI from the client record(s) of:

| Last | First | Middle | Date of Birth |
|---|---|---|---|
| | | | / / |

**With/TO:** _____

_____

**(Name/ Address of person/organization to which disclosure is to be made)**

TO PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making any further disclosure without the specific written consent of the person whom it pertains, or otherwise permitted by such regulations.

I, the undersigned, understand that a copy of this signed authorization form is as acceptable as the original.

**The protected health information to be disclosed includes the following:**

- ◯ Assessment Information
- ◯ Diagnosis
- ◯ Treatment Plan
- ◯ Progress & Treatment Notes
- ◯ Communicable Disease Information
- ◯ Medication
- ◯ Psychiatric Evaluation
- ◯ Results of Psychological Testing
- ◯ Recommendations
- ◯ Reason for Termination
- ◯ Number of kept/unkept Appointments
- ◯ Results of Clinical Polygraphs

Other (please specify): _____

**For the purpose of:**

- ◯ Continued Care
- ◯ Education
- ◯ Legal
- ◯ Insurance
- ◯ Collaboration
- ◯ Other: _____

**This release will expire:**

- ◯ at the end of 60 days
- ◯ at the termination of treatment
- ◯ as of: _____
  (Specify Date)

I understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

| CLIENT SIGNATURE | PARENT/ GUARDIAN/ LEGAL REPRESENTATIVE SIGNATURE | Therapist Signature |
|---|---|---|
| X | X | X |
| **DATE** ____/____/____ | **DATE** ____/____/____ | **DATE** ____/____/____ |

# PERMISSION TO TREAT MINOR PATIENT

Today´s Date ____/____/____

**DKS Counseling LLC** must receive permission from a child´s parent or legal guardian, prior to providing treatment(s) for preventive care, injury or illness that is non-life threatening. This form provides the legal permission to either treat without any adult present (Section A), or with a Designated adult present (Section B)

Patient´s Name _____ Patient´s DOB _____

**Section A:** Authorization to treat your minor child in case you or your designated representative is unable to accompany your child to one of his/her visits: I, (print parent/ legal guardian name) _____ give **DKS Counseling LLC** permission to either treat without any adult present (Section A), or with a Designated adult present (Section B)

**Section B:** Delegation of authority for treatment of a minor child to the designated representative indicated below: I, print parent/ legal guardian name) _____ grant **DKS Counseling LLC** permission to assess and treat the aforementioned minor in the presence of either of the following adults (you may choose more than one), who is authorized to approve treatment:

Name: _____ Relation to Minor: _____

Name: _____ Relation to Minor: _____

**NOTE: A parent / legal guardian MUST be present for a minor patient´s first visit with DKS Counseling LLC.**

This authorization is valid for (length of time): _____

This visit only (date of appointment): _____

Until otherwise revoked (Initial): _____

Authorized by: _____ Date ____/____/____

Emergency Contact Phone Number: _____