PEACEFUL HEALING
COUNSELING SERVICES

New Client Intake Form

Demographic Information

Client Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Emergency Contact Name & Phone Number: _____

Preferred Method of Contact: Text Email Phone Call

By choosing text communication, you agree to receiving texts from Peaceful Healing Counseling Services, PLLC.* ***Messaging and data rates may apply.**

Health Insurance Information

If you are paying without your insurance, please skip this section. You will be asked to complete a cash agreement form.

Primary Insurance Provider: _____

Primary Insurance Identification Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Secondary Insurance Provider: _____

Secondary Insurance Identification Number: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Employer: _____

PEACEFUL HEALING
COUNSELING SERVICES

Intake Questionnaire

What brings you to counseling?

_____
_____
_____
_____
_____
_____

In your family, is there a history of any of the following:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Other: _____
- ☐ Trauma
- ☐ Schizophrenia
- ☐ Substance Use
- ☐ Obsessive Compulsive Disorder

If yes, whom? _____

Have you ever been admitted to a hospital for mental health concerns? Yes No

If so, when, where, and for what specific concern? _____

Are you taking any medications? Yes No

If so, please notate the name, dosage, and for what reason below.

Name of Medication & Dosage	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you experiencing any thoughts about death? Yes No

If yes, please rate the intensity of your thoughts, from 0-7, 0 being not stressful at all and 7 being the most intense thought possible.

0 1 2 3 4 5 6 7

Are you currently engaging in self-harm? Yes No
Are you drinking alcohol? Yes No
Are you using recreational drugs? Yes No
Do you use marijuana for recreational purposes? Yes No

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Billing Policy

Thank you for choosing Peaceful Healing Counseling Services, PLLC for your counseling needs. We understand that many clients find insurance coverage and financial responsibility issues complex and confusing so we have outlined our practice's policy for complete transparency.

What Is My Financial Responsibility?

Your financial responsibility depends on a variety of factors, explained below:

1. If you have a health insurance plan and the provider is not a participating provider or beneβits are considered out-of-network, you will be responsible for paying 100% of the provider's full charges. We will submit an insurance claim to your insurance carrier on your behalf, and you will be responsible for fees not covered by your insurance. Any outstanding balances are due **upon receipt**.
2. If you have a health insurance plan, and your therapist is a participating provider or benefits are considered in-network, you will be responsible for paying your deductible, copayments and any other financial obligation as stated in your plan. We will inform you of any services not covered by your plan as well as submit an insurance claim to your insurance carrier. Any outstanding balances are due upon receipt.

Clients Who Are Minors

A parent or legal guardian must accompany clients who are minors on the patient's first visit. This accompanying adult is responsible for payment of the account, according to the policy outlined on the previous sections, or must provide complete and accurate information about the guarantor on the insurance that will be billed.

Agreement Confirmation

I have read, understand, and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayment and deductible are my responsibility and are payable immediately upon receipt of patient statement. I authorize my insurance benefits to be paid directly to Peaceful Healing Counseling Services, PLLC or Jennifer Chicoine. I authorize Peaceful Healing Counseling Services, PLLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. ***I understand that if I do not pay my balance within 90 days, my bill may be sent to a collections agency and services will pause until payment is made in full.***

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

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Credit Card Authorization

All clients are required to place a card on file for any outstanding balances in your account.

Name on Front of Card: _____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Zip Code: _____

By signing below, you hereby authorize Peaceful Healing Counseling Services, PLLC to initiate a credit/debit card transaction to the above designated bank account for the total balance on your client account. You further authorize your Financial Institution to deduct this payment from your account.

You understand that in the event Peaceful Healing Counseling Services, PLLC is unable to secure the funds for this transaction from your account for any reason, including but not limited to insufficient funds in your account or insufficient or inaccurate information provided when you submit your electronic payment, further collection action may be undertaken by Peaceful Healing Counseling Services, PLLC to the extent permitted by law. You further understand that the submission of this transaction is considered proper authorization by you for Peaceful Healing Counseling Services, PLLC to initiate credit/debit card transactions to your account for such fees.

In the event of a dishonored payment, your obligation to Peaceful Healing Counseling Services, PLLC will remain unpaid, and if not rectified within 30 days, your balance, along with relevant demographic information, will be sent to a Collections Agency and services will be paused until the balance is paid in full.

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

PEACEFUL HEALING
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Informed Consent

This therapist, Jennifer Chicoine, M.A., LCPC, and Peaceful Healing Counseling Services, PLLC are required by Illinois State Law as a mandated reporter to contact local authorities and ***must*** breach confidentiality if a client discloses one of the following instances:

1. An inability to keep themselves safe against self-harm or suicide.

2. An inability to keep themselves from hurting others, in any way shape or form.

3. If you have disclosed/admitted to abuse of any kind to a minor.

This therapist will also report evidence of abuse to a minor to the Department of Children & Family Services (DCFS) if this therapist feels it is warranted.

This therapist has a 'Duty to Warn' any person, breaching their client's confidentiality, if a client discloses that they intend to harm any person in any way.

If you understand the standard reporting procedures required by Illinois State Law and the American Counseling Association Code of Ethics, please read the following statements and sign this form below.

I have read and reviewed the above information and asked any questions I have regarding this information. My questions have been answered to my satisfaction.

I understand that my confidentiality will be breached if this therapist needs to contact local authorities for an emergency-related situation, DCFS, or provide required 'Duty to Warn' practices.

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

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Informed Consent, Continued: Electronic Communications Disclosure

Although Peaceful Healing Counseling Services, PLLC and its owners, members, employees, staff, interns, and students utilize best practices to maintain Patient Protected Health Information (PHI), email, text, or electronic correspondence between therapists and clients run the risk of confidentiality being breached under the following circumstances:

1. Email/electronic/text communication can be intercepted by someone who is not the intended recipient.
2. Intercepted correspondence can be printed out by the unauthorized recipient.
3. Your identity can be determined if your name is part of your email address.
4. Email and texts sometimes unintentionally go to unintended recipients.
5. Email/texts can transport computer viruses and other malicious software, not intended by this therapist or anyone affiliated with this organization.
6. Detailed identifying information should not be transferred via email or text in a form of an attachment, in the body of the email or text, or in the subject line.

In addition, the purpose of your admission to treatment is to discuss your concerns during your scheduled session time. Any communication outside of your scheduled session should be brief. If you feel you may forget the information you wish to share, it is encouraged to write your thoughts in a journal and bring them to your next scheduled session. **ANY COMMUNICATION OUTSIDE OF YOUR SCHEDULED SESSION TIME THAT IS NOT RELATED TO SCHEDULING OR BILLING MAY RESULT IN AN ADDITIONAL CHARGE TO YOUR INSURANCE COMPANY.**

EMERGENCIES

It is ***NOT*** recommended to call, email, or text Peaceful Healing Counseling Services, PLLC or this therapist in case of any emergency because we are not an emergency facility. In any case of emergency, please dial 911, 988, or go to your nearest emergency room. If you contact Jennifer or Peaceful Healing Counseling Services, PLLC regarding an emergency, we are not equipped or trained to handle emergencies and may not respond. Please understand that if you choose to contact this therapist via text, call, or email, they will return your email within 48 business hours.

Other resources to contact in case of a mental health crisis:

1. National Suicide Prevention Hotline: 800.273.8255 or 988.
2. 911 for Police, Fire, or Emergency Medical Technicians (EMTs).
3. Text "CONNECT" to 741741 if you wish to text a crisis counselor from the Crisis Text Line.

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TEXT

Peaceful Healing Counseling Services, PLLC receives texts regarding scheduling and rescheduling ONLY. Please do not text information you wish to discuss in session via text. All texts will be replied to within 48 business hours, if they are pertaining to scheduling.

EMAIL

You are more than welcome to send an email with any updates you wish to provide Jennifer. However, please be mindful of the above circumstances of breached confidentiality that may occur. If you have a considerable amount of information to communicate via email, please call and schedule an additional appointment to discuss your questions or concerns. ***It is recommended that you write down your questions, comments, concerns, and thoughts in a journal and bring it to your scheduled sessions each week, so you can discuss your questions during your scheduled visit.***

SOCIAL MEDIA

Peaceful Healing Counseling Services, PLLC has a public Facebook page and Instagram page to promote mental health awareness as well as clinic notices. You are more than welcome to follow those pages; however, please do not request communication through those social media profiles. This could potentially violate your privacy by exposing your friends and family to your relationship with the professional business page and question your relationship to the business. By interacting with the social media pages of Peaceful Healing Counseling Services, PLLC, you understand that this could violate your privacy, at your own risk.

INTERACTIONS IN PUBLIC

It is prohibited for this counselor or its members, employees, staff members, owners, managers, affiliates, interns, or students to initiate contact in any way with clients of Peaceful Healing Counseling Services, PLLC outside of the clinic. Any interactions that occur outside of the clinic will not be initiated by this therapist, as a way to respect your privacy in accordance with HIPAA privacy guidelines. If you notice this therapist in public, you may initiate contact, only if you understand that you are at risk of breaching your confidentiality. This counselor will not discuss clinical matters in public settings.

I understand that it is required by State and Federal law that licensed healthcare professionals are to try their best to keep my records protected, which is why this therapist is providing me with the above information. I understand that I am not required to participate in text, email, or electronic correspondence with this therapist, and I can withdraw consent at any time by notifying this therapist directly. By signing below, I provide permission to electronically communicate with this therapist, and I will not hold Peaceful Healing Counseling Services, PLLC or its owners, members, managers, employees, interns, students, or staff responsible for any viruses, malware, tracking, or identity theft if I decide to participate in electronic communication.

Client Name: _____ Date of Birth: _____

Your Printed Name (if different than above): _____ Relationship to Client:_____

Signature: _____ Date: _____

PEACEFUL HEALING
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Cancellation Policy

Here at Peaceful Healing Counseling Services, PLLC, we completely understand that life happens and you will need to cancel from time-to-time. However, out of respect for the staff and other clients, it is important for you to be prompt about canceling or rescheduling your sessions should you can't make your appointment time or be more than 20 minutes late to your appointment.

If you need to reschedule or cancel your appointment, please do so at least 24 hours before your scheduled time. If you cancel within 24 hours of your appointment time, you will be charged a **$100.00 late cancellation fee**. If you fail to call and miss your appointment (no call/no show), you will be charged a **$125.00 no show fee.** If you cancel more than 2 consecutive times, then the therapist may remove you from their schedule until a better time and day can be determined that works for your schedule. We would like to accommodate you so that you can be consistent with your sessions. Therapy is most beneficial when it is consistent.

Peaceful Healing Counseling Services, PLLC reserves the right to modify, amend, or change its cancellation policy at any time, without prior notice or consent, at the discretion of the practice. Such changes shall be effective immediately upon posting or notification to clients. Clients are encouraged to regularly review policy terms to ensure awareness of any modifications. By continuing to engage in services, clients agree to comply with the most current version of the cancellation policy. Should any questions arise, clients are advised to contact the practice for further clarification.

By signing below, I understand the above cancellation policy and agree to the terms.

Client Name: _____ Date of Birth: _____

Your Printed Name (if different than above): _____ Relationship to Client:_____

Signature: _____ Date: _____

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Anticipated Fees for Services

Please take this document with you for your records.

<u>Counseling Formats and Billing Explanations</u>

Diagnostic Evaluation - $200.00

A diagnostic evaluation is most often the very βirst session that you will attend. This session serves as the initial assessment of your concerns. The therapist will ask you a series of questions and administer a series of assessments to determine the best course of treatment for your reported problem.

Individual Counseling Sessions (30 minutes or 60 minutes) - $125.00/$175.00

Individual psychotherapy sessions occur most often and include you and the therapist.

Family Counseling Sessions - $200.00

Family psychotherapy (with patient) sessions include you and one or more members of your family. This may occur in the form of sibling sessions, parent/guardian and child sessions, and/or sessions with the whole family unit. Your therapist will work with your family to determine if family sessions are appropriate for your treatment.

Couples' Counseling Sessions - $200.00

Couples' therapy includes two or more members within a relationship, civil union, or marriage.

Crisis Therapy - $175.00

Crisis sessions occur when the therapist has reason to believe that the client is a danger to themself or another person. Issues addressed in crisis sessions may include suicidal ideation or intent, homicidal ideation or intent, non-suicidal self-injury, reports of child/elderly abuse, etc. Additional time beyond the crisis session may be needed for the therapist to contact the necessary authorities, including DCFS, the police, and/or medical personnel. The therapist may also continue to follow up with you for the days following the crisis session to ensure the safety plan was established and maintained. This time includes direct services to you as well as follow-up, documentation, and calls with appropriate personnel.

Pediatric Therapy Formats

Diagnostic Evaluation - $200.00

A diagnostic evaluation is most often the very βirst session that you will attend. This session serves as the initial assessment of your concerns. The therapist will ask you a series of questions and administer a series of assessments to determine the best course of treatment for your reported problem.

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Individual Counseling Sessions (30 minutes or 60 minutes) - $125.00/$175.00
Individual psychotherapy sessions occur most often and include your child and the therapist. The therapist may meet with you before and/or after the session to discuss your child's successes, challenges, and strategies for at-home use. Please reserve 1-5 minutes at the start and end of each session for parent/guardian support or feedback.

Family Counseling Sessions (without patient) - $150.00
Family psychotherapy sessions that do not involve your child are commonly referred to as "parent/guardian support sessions." Your child's therapist may facilitate these sessions to provide further information about your child's treatment and to discuss strategies that can be used at home. Parent/guardian support sessions also serve as a safe space to answer any questions you may have about your child's treatment or to share any information that you are not comfortable providing in front of your child. Please be advised that parent/guardian support sessions lasting 26 minutes or longer can likely be billed to your insurance. Please verify with your therapist that these sessions are covered. Parent/guardian support sessions can be scheduled relatively flexibly and may occur in person or via telehealth. Therapists often allocate 60 minutes for these sessions.

Interactive Complexity - $20.00
Interactive complexity is commonly used in counseling sessions with children and adolescents. Interactive complexity is an add-on billing code that may accompany individual counseling services to improve the communication process between the therapist, child, and/or family. Therapists may use books, toys, sensory equipment, communication devices, and other tools to improve the counseling process for your child.

IEP/504 Plan Meeting - $150.00 (not billable to insurance)
Counselors may be asked to participate in formal meetings with school personnel to discuss and review the child's individualized education plan (IEP) or 504 plan. Such plans include accommodations to help the child thrive in the academic setting.

Non-IEP School Meeting - $125.00 (not billable to insurance)
Counselors may be asked to participate in scheduled meetings with school personnel to discuss the child's challenges, successes, and possible behavioral techniques for school use. These meetings are different from IEP and 504 plan meetings in that they may address issues outside of the accommodations already in place. The self-pay rate for this service will be $150 per hour and may be paid by the parent/guardian or the school depending on the party requesting the meeting.

PEACEFUL HEALING
COUNSELING SERVICES

Your Rights & Responsibilities as a Counseling Client

If you'd like a copy of this document, please ask an associate to make a copy for you.

As a client of Peaceful Healing Counseling Services, PLLC, **you have the right to**:

- Select a professional counselor who meets your needs.
- Receive specific information about your counselor's qualifications, including education, experience, national counseling certifications, and state licensure.
- Obtain a copy of the code(s) of ethics your counselor must follow.
- Receive a written explanation of services offered, time commitments, fee scales, and billing policies prior to receipt of services.
- Understand your counselor's areas of expertise and scope of practice (e.g., career development, adolescents, couples, etc.).
- Ask questions about confidentiality and its limits as specified in state laws and professional ethical codes.
- Receive information about emergency procedures (e.g., how to contact your counselor in the event of a crisis).
- Ask questions about counseling techniques and strategies, including potential risks and benefits.
- Establish goals and evaluate progress with your counselor.
- Request additional opinions from other mental health assessment professionals.
- Understand the implications of diagnosis and the intended use of psychological reports.
- Obtain copies of records and reports.
- Terminate the counseling relationship at any time.
- Share any concerns or complaints you may have regarding a professional counselor's conduct with the appropriate professional counseling organization or licensure board.

In order for your counselor to provide the highest quality of services, **it is important that clients**:

- Adhere to established schedules. If you must miss an appointment, contact your counselor as soon as possible.
- Pay your bill in accordance with the billing agreements.
- Follow agreed-upon goals and strategies established in sessions.
- Inform your professional counselor of your progress and challenges in meeting your goals.
- Participate fully in each session to help maximize a positive outcome.
- Inform your counselor if you are receiving mental health services from another professional.

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- Consider appropriate referrals from your counselor.
- Avoid placing your counselor in ethical dilemmas, such as requesting to become involved in social interactions or to barter for services.

What to Do if You Are Dissatisfied

Remember that a counselor who meets the needs of one person may not meet the needs of another.

If you are dissatisfied with the services of your counselor:

- Express concerns directly to the counselor, if possible.
- Seek the advice of the counselor's supervisor if the counselor is practicing in a setting where he or she receives direct supervision.
- Terminate the counseling relationship if the situation remains unresolved.
- Contact the appropriate state licensing board, national certification organization, or professional association if you believe the counselor's conduct to be unethical.

By signing below, I agree that I have received a copy of this document and agree to the terms. I understand that I can ask for a paper copy upon request.

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

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Mental Health Crisis Disclosure

Please take this document for your records.

We understand the multitude of mental health problems in the world today. If you or a loved one are experiencing a mental health emergency, please take advantage of these resources that are available to the public. **Please note** that Peaceful Healing, or any outpatient mental health practice, is not considered an emergency facility, and you should go to your nearest emergency room for help.

Important Phone Numbers

Suicide & Crisis Lifeline: 988 or text "HOME" to 741741
Veterans Crisis Line: 1.800.273.8255 or text 838255
Screening, Assessment, and Support Services (SASS): 1.800.345.9049
Disaster Distress Helpline: 1.800.985.5990
National Human Trafficking Hotline 888.373.7888 or text "HELP" to 233733
NAMI Chicago Helpline: 1.833.626.4244
Domestic Violence Hotline: 1.800.799.7233
National Suicide Prevention Hotline: 1.800.273.8255
Substance Use Helpline: 1.833.234.6343 or text "HELP" to 833234
Trans Lifeline: 1.877.565.8860
Veterans The Road Home: 1.312.942.8387
Housing Services for Adults: 311
Housing Services for Youth: 1.877.870.2663
National Runaway Safeline: 1.800.786.2929
Chicago Rape Crisis Hotline: 1.888.293.2080
National Sexual Assault Hotline: 1.800.656.4673

24-Hour Emergency Psychiatric Evaluation Centers

630-305-5027 Linden Oaks 24 hour, in-person assessment
844-580-5000 Silver Oaks 24 hour, in-person assessment
708-684-8000 Christ Medical Center 24 hour, in-person assessment

Information for Veterans

https://www.sokolovelaw.com/about-us/healthcare-resources-for-veterans/

Information for Cancer Support

https://www.simmonsfirm.com/about-us/giving-back/cancer-institute/

Information for the Crisis Center for Domestic Violence

https://www.crisisctr.org/

Information for Helping Survivors

helpingsurvivors.org/resources/

PEACEFUL HEALING
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HIPAA Privacy Disclosure

If you'd like a copy of this document, please ask an associate to make a copy for you.

This disclosure serves as information as to how your or your child's medical information will be utilized throughout treatment and how you can access this information. Peaceful Healing Counseling Services, PLLC provides this information to you in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Peaceful Healing Counseling Services, PLLC and its members, owners, managers, agents, employees, and interns are required by law to:

1. Maintain the privacy of protected health information (PHI).
2. Give you this notice of our legal duties and privacy practices of your or your child's health information.
3. Follow the terms of this notice currently in effect.

How We May Disclose Your or Your Child's Information

We may use your or your child's health information without further authorization using the methods below:

For treatment: We may use your protected health information to provide treatment to your child, specifically discussing treatment with doctors, nurses, health students, or other personnel who are involved in your or your child's care. We may also consult with other mental health professionals to ensure we are making the most appropriate decisions regarding your or your child's care.

For payment: We may use your protected health information to ensure services are covered under insurance, or so Peaceful Healing, LLC can receive payment for services rendered. For healthcare operations: We may use your protected health information to improve business practices and quality of care. For example, we may use your protected health information to contact you directly to discuss scheduling, canceled appointments, insurance updates, billing, and/or payment matters.

As required by law: We will disclose protected health information when required to do so by law.

To avert a serious threat or injury: We may use and disclose health information when necessary to prevent a serious threat to you or your child's health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Workers' Compensation: We may release health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Public Health Risks: We may disclose information about your child for public health activities – for example, to prevent or control disease or to notify people of recalls of products they may be using.

Individuals Involved in Your Care or Payment for Your Care: If people such as family members, relatives, or close personal friends are helping to care for you or your child or helping to pay for your or your child's medical bills, we

may release health information to them. This is limited to the necessary information for care or for payment for care.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement: We may release health information if asked to do so by law enforcement officials. For example, we may report certain injuries as required by law such as gunshot wounds or in response to a court order, subpoena, warrant, summons, or similar process.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information in response to a court or administrative order. We also may disclose health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Protective Services for the President and Others: We may disclose health information about you or your child to authorized officials so they may provide protection to the president, other authorized persons or foreign heads of state, or to conduct special investigations.

Your Rights Regarding Health Information About You or Your Child
You have the following rights regarding health information we maintain about you or your child:

Right to Inspect and Copy: Upon written request, you have the right to receive an electronic or paper copy of your child's medical records and other health information. Usually this includes health and billing records. If you request a copy of the information, we may charge a fee for the cost of copying, mailing, or other supplies and services associated with your request.

Right to Amend: If you feel that health information we have about you or your child is incorrect or incomplete, you may ask us to amend the information. Your request must be submitted in writing to Peaceful Healing Counseling Services, PLLC's owner and sole proprietor, Jennifer Chicoine, and it must be legible. In addition, you must provide a reason that supports your request for an amendment. We may deny your request if you ask us to amend information that was not created by us, or if the information is accurate and complete.

Right to Accounting of Disclosures: You have the right to an accounting of disclosures of you or your child's health information, except for uses and disclosures related to treatment, payment, others with your permission and our health care operations, as previously described. To request this list of disclosures, you must submit the request in writing to Peaceful Healing Counseling Services, PLLC's owner and sole proprietor, Jennifer Chicoine.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about your child for treatment, payment, or health care operations. Unless the request is to restrict

disclosures to your health plan and you agree to pay out of pocket in full for all services provided, we are not required to agree to your request for restrictions unless it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must submit your request in writing to Peaceful Healing Counseling Services, PLLC's owner and sole proprietor, Jennifer Chicoine.

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 can ask that we contact you only at work or by mail to a post office box. To request confidential communications, you must make your request in writing to Peaceful Healing Counseling Services, PLLC's owner and sole proprietor, Jennifer Chicoine. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from the front desk.

Complaints: You can file a complaint with Peaceful Healing Counseling Services, PLLC's owner, Jennifer Chicoine, or with the U.S. Department of Health and Human Services Office for Civil Rights. All complaints must be made in writing. Filing a complaint will not affect your child's treatment or services. To file a complaint with the U.S. Department of Health and Human Services, call 1.877.696.6775, visit www.hhs.gov/ocr/privacy/hipaa/complaints, or send a letter to: 200 Independence Avenue, SW, Washington, D.C., 20201.

I've read and understand the summary of the HIPAA privacy practices of Peaceful Healing Counseling Services, PLLC, and I agree to the terms.

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

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Medical Release Authorization

Client Name: _____ Date of Birth: _____

I grant permission for Peaceful Healing Counseling Services, PLLC to:

- ☐ Disclose
- ☐ Obtain
- ☐ Disclose and obtain

any healthcare information in my or my child's record to the parties listed below:

Name	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

I grant permission for Peaceful Healing Counseling Services, P LLC to disclose information related to the below topics that I've
initialed below:

_____ Evaluation and session notes
_____ Diagnoses provided by Peaceful Healing Counseling Services, PLLC or from doctors or other healthcare providers
_____ Medical history
_____ Assessment scores administered by Peaceful Healing Counseling Services, PLLC
_____ Appointment dates and times
_____ Parent concerns relating to therapy (if applicable)
_____ Information disclosed in your child's IEP (individual education plan) or 504 plan (if applicable)

By signing below, I agree for Peaceful Healing Counseling Services, PLLC to disclose any information permitted above to the above-mentioned parties. I agree that Peaceful Healing Counseling Services, PLLC does not need my permission to contact local law enforcement and child protective services if they feel it is necessary to do so.

Client Name: _____ Date of Birth: _____
Your Printed Name (if different than above): _____ Relationship to Client:_____
Signature: _____ Date: _____

THIS RELEASE IS VALID FOR ONE YEAR FROM THE DATE OF SIGNATURE UNLESS OTHERWISE STATED

PEACEFUL HEALING
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Counseling Terms & Conditions

Please read and <u>initial</u> the terms and conditions for Peaceful Healing Counseling Services, PLLC's counseling process to ensure you understand the standard terms of treatment.

When does counseling begin to work?

_____ Counseling is a slow and steady process, and it will not work in an instant. The first few sessions are strictly so you can build rapport with this counselor. Counseling can take anywhere from 3 - 12 months to be truly effective, depending on the person and depending on the severity of the situation. Please be patient with yourself and this counselor during this process.

What should I do if I am going to be late?

_____ If you are going to be late to an appointment, please call the front desk directly and inform them as soon as possible. If you will be more than 20 minutes late, it is best to reschedule the session as 30 minutes is typically not effective for counseling.

What should I do if I need to miss a session?

_____ If you are going to miss a session, it is important that you call the clinic and inform the front desk as soon as possible. A fee may accrue for canceling a session within 24 hours. PLEASE NOTE: it is crucial for you to consistently attend your weekly counseling session as this is the only way counseling is effective. This counselor understands if you're sick, but please make sure to let the front desk know as soon as you can.

How do I know when I am ready for discharge?

_____ When you feel that you're ready to discharge, please discuss your opinion with your counselor so we can begin discussing your discharge plan.

Client Name: _____ Date of Birth: _____

Your Printed Name (if different than above): _____ Relationship to Client:_____

Signature: _____ Date: _____

PEACEFUL HEALING
COUNSELING SERVICES

Telehealth Policy

1. Services Provided: I, _____, understand that Jennifer Chicoine, M.A., LCPC, CCTP will provide mental health counseling services to me via telehealth, which includes but is not limited to video conferencing, telephone calls, and secure messaging. **I understand that I must be physically in the state of Illinois while Telehealth services are being rendered.**

2. Scope of Services: I understand that telehealth services may include individual therapy, crisis intervention, psychoeducation, and other mental health services deemed appropriate by Jennifer Chicoine, M.A., LCPC, CCTP.

3. Informed Consent: I have been informed of the risks, benefits, and limitations of telehealth services. I understand that telehealth may not be appropriate for all situations and emergencies, and I have been provided with emergency contact information.

4. Confidentiality: I understand that all communications between me and Jennifer Chicoine, M.A., LCPC, CCTP will be confidential and protected by state and federal laws, including HIPAA regulations. I consent to the use of secure and HIPAA-compliant technology for telehealth sessions.

5. Technology Requirements: I acknowledge that it is my responsibility to ensure access to necessary technology and a stable internet connection for telehealth sessions.

6. Payment and Insurance: I understand that payment for telehealth services is my responsibility, and I agree to discuss insurance coverage and payment arrangements with Jennifer Chicoine, M.A., LCPC, CCTP prior to beginning services.

7. Record-Keeping: I understand that Jennifer Chicoine, M.A., LCPC, CCTP will maintain secure and accurate records of our telehealth sessions in compliance with state laws and professional standards.

8. Rights and Responsibilities: I understand my rights and responsibilities as a client receiving telehealth services, including the right to ask questions, request changes in treatment, and provide feedback.

9. Dispute Resolution: In the event of any disputes regarding telehealth services, I agree to follow the procedures outlined by Jennifer Chicoine, M.A., LCPC, CCTP for resolution.

10. Agreement Duration: This agreement will remain in effect unless terminated by either party in writing. I understand that I have the right to terminate telehealth services at any time.

11. Signature: I have read and understand the terms of this Telehealth Counseling Services Agreement. By signing below, I agree to participate in telehealth services provided by Jennifer Chicoine, M.A., LCPC, CCTP.

Client Name: _____ Date of Birth: _____

Your Name (if different than client): _____

Signature: _____ Date: _____