CHICAGO CHRISTIAN COUNSELING CENTER

PRELIMINARY INTAKE INFORMATION

Please provide the information requested in the spaces provided. This and all other information relating to your association with Chicago Christian Counseling Center is regarded as strictly confidential and will not be shared with anyone without your signed consent. (Please print legibly)

Client First Name_____Last Name_____Date_____

Address_____City_____State_____Zip_____

Phone (____)_____ h/w/c Phone(____)_____h/w/c

Social Security #_____or Driver's License #_____

DOB___/___/___ Age_____ Sex (M/F) _____ Marital Status: S M Sep D W

Email: _____

I would like to receive: (please check) ☐ Appointment Reminder Email ☐ CCCC e|Newsletter (emailed articles by therapists)
☐ No thanks, not at this time.

Please provide parent/guardian information if client is a minor, or 2nd party information if couple counseling.

Name_____ Relationship to client_____

Address (if different from above)_____

City _____State_____ Zip_____ Phone (_____)_____h/w/c

DOB___/___/___ Age_____ Sex (M/F) _____ SS# _____

Primary Care Physician_____ Phone (_____)_____

Employer/School (if any)_____

Church Affiliation (if any)_____Denomination_____

Were you raised in a religious home? (Circle one) Yes No

How important is your religion or faith to you today? (Check one)
___Very Important ___Somewhat Important ___Not Important

EMERGENCY INFORMATION

Emergency Contact_____ Relationship_____

Address_____City_____State_____Zip_____

Home Phone_____Alternate_____

BILLING INFORMATION

We will make a copy of your insurance card(s) to ensure proper filing of claims.

Primary Insured _____DOB ___/___/___ SS#_____

Relationship to Client □ Self □ Spouse □ Parent □ Other_____

Employer_____

Primary Insurance Carrier _____ Phone _(_____)_____

Claims Address_____

ID#_____ Group#_____

Secondary Insured _____DOB ___/___/___ SS#_____

Relationship to Client □ Self □ Spouse □ Parent □ Other_____

Employer_____

Secondary Insurance Carrier _____ Phone _(_____)_____

Claims Address_____

ID#_____Group#_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the Chicago Christian Counseling Center to (A) furnish information concerning my diagnosis and treatments to my insurance carrier(s) and (B) request my insurance carrier(s) to direct payment to the Chicago Christian Counseling Center.

Client/Authorized Person's Signature: _____Date _____

CONFIDENTIALITY

All information regarding clients is considered strictly confidential and will not be given to anyone outside of Chicago Christian Counseling Center without your written consent. In the event of a request for the transfer of records to another party, the records will be forwarded directly to that party only upon receipt of your written request.
I give my consent to_____(therapist) to provide evaluation and treatment that we may mutually determine to be appropriate. I am participating in my treatment voluntarily and understand that I have the right to refuse or discontinue treatment at any time. I have had the opportunity to discuss reasons for seeking services and I understand my responsibilities in this therapeutic relationship.

_____ (Please initial if applicable) I understand that the above named therapist is receiving weekly supervision from a Chicago Christian Counseling Center licensed therapist.

Client
Signature_____Date_____

Parent/Guardian
Signature_____Date_____

*(Please Print) Client Last Name*_____*First Name*_____

OFFICE & FEE POLICIES

Thank you for choosing us as your counseling services provider. We are committed to helping you reach your goals. We ask that you commit yourself to the timely payment of your agreed upon portion of the charge. The following is a statement of our financial policy:

- We require payment in full at the time of service unless prior arrangements have been made with your healthcare professional. HMO, PPO, and Medicare clients are expected to pay the co-payment portion at the time of service
- We accept cash, checks, Visa, Mastercard, or Discover.
- There will be a $15.00 charge for any returned check.
- As a service to you, whenever your insurance company will work with us, we will process your insurance claims.
- Benefits payable are determined by the insured's eligibility, the limitations, exclusions and conditions of the plan. Benefits are determined at the point the claim is processed.
- **Insurance quotes by our staff are not a guarantee of benefits. If you have questions regarding your benefits, please call your insurance company directly.**
- **If insurance does not pay, all agreed upon expenses will be the responsibility of the client.**
- **It is the responsibility of the client to notify the office 24 hours in advance when cancelling an appointment If 24 hour notice is not given a $50.00 late cancellation fee will be charged. Insurance does not cover missed appointments.**
- Account balances, which remain unpaid for more than 90 days, may be forwarded to collection agency. The client will bear the full cost of collection activity and any legal fees incurred.

I have read and I understand the above policies.

Financially Responsible Party_____

Relationship to client_____

Address_____City_____State_____Zip_____

Phone_____Alternate_____

SS#_____DOB_____/_____/_____

Signature_____ Date_____

Granting Permission Regarding Billing and/or Scheduling

From time-to-time you may want/need to have someone, on your behalf, contact a member of our staff about your bill and/or your appointments. Please indicate the name(s) of those individuals authorized by you to speak to our staff.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☐ Billing Only ☐ Scheduling Only ☐ Both

☐ I do not want to grant permission to other people to discuss Billing and/or Scheduling with your staff on my behalf.

Client Signature_____**Date**_____

OFFICE USE ONLY: Therapist: _____Office: _____

*(Please Print) Client Last Name*_____*First Name*_____

SYMPTOM CHECKLIST A

(primary client or parent/guardian of minor)

Date_____

*(Please Print) Client Last Name*_____*First Name*_____

Statement of problem(s) for which you now seek counseling:

_____
_____
_____
_____

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	**Never**	**Sometimes**	**Often**
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

When did the symptoms first begin?____/____/____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)

SYMPTOM CHECKLIST B
(Spouse or Minor)

Date_____

*(Please Print) Client Last Name*_____*First Name*_____

Statement of problem(s) for which you now seek counseling:
_____
_____
_____
_____

Please rate the degree to which you have been experiencing the following problems during the PAST MONTH by making an "X" in the appropriate box.

Symptom	**Never**	**Sometimes**	**Often**
Anxiety			
Depression			
Fears/fearfulness			
Angry outbursts (temper)			
Eating problems			
Sleep problems			
Fatigue			
Alcohol and/or drug problems			
Stress			
Work/school problems			
Family problems			
Child-rearing problems			
Problems getting along w/others			
Violence			
Health problems			
Legal problems			
Financial problems			

When did the symptoms first begin?____/____/____ (date)

Have you ever been treated for these symptoms before?_____Yes _____No

If yes, when? ____/____/____(date)

CHICAGO CHRISTIAN COUNSELING CENTER

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Locations in Chicagoland and Northwest Indiana

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT OUR PATIENTS MAY BE USED AND DISCLOSED AND HOW THEY CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: CHICAGO CHRISTIAN COUNSELING CENTER is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to patients' PHI. This Notice describes legal rights, advises of our privacy practices and outlines how CHICAGO CHRISTIAN COUNSELING CENTER is permitted to use and disclose PHI about our patients.

CHICAGO CHRISTIAN COUNSELING CENTER is also required to abide by the terms of the version of this Notice currently in effect. In most situations we may use this information as described in this Notice without permission, but there are some situations where we may use it only after we obtain our patients' written authorization, if we are required by law to do so.

Uses and Disclosures of PHI: CHICAGO CHRISTIAN COUNSELING CENTER may use PHI for the purposes of payment and health care operations, in most cases without written permission. Examples of our use of PHI:

For treatment: This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

For payment: This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.

CHICAGO CHRISTIAN COUNSELING CENTER will not use or disclose more information for payment purposes than is necessary. This is known as using only the minimum necessary amount to accomplish the purpose of use or disclosure. We are accountable to the Secretary of Health and Human Services to safeguard (keep secure) and protect (keep private) our patients' information.

For health care operations: This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

Notification in the Case of a Breach: CHICAGO CHRISTIAN COUNSELING CENTER is required by law to notify our patients in case of a breach of their unsecured protected health information when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.

Use and Disclosure of PHI Without Your Authorization: CHICAGO CHRISTIAN COUNSELING CENTER is permitted to use PHI *without* written authorization, or opportunity to object in certain situations, including:

1. For CHICAGO CHRISTIAN COUNSELING CENTER's use in obtaining payment for services provided or in other health care operations;
2. To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
3. To another health care provider (such as the hospital) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with our patients and the PHI pertains to that relationship;
4. For health care fraud and abuse detection or for activities related to compliance with the law;
5. In situations where our patients are not capable of objecting (because the patients are not present or due to incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to our patient's family member, relative or friend is in the best interest. In that situation, we will disclose only health information relevant to that person's involvement in our patient care;
6. To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects or to notify a person about exposure to a possible communicable disease) as required by law;
7. For health oversight activities including audits or government investigations, inspections, disciplinary proceedings and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
8. For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
9. For law enforcement activities in limited situations, such as when there is a warrant for the request or when the information is needed to locate a suspect or stop a crime;
10. For military, national defense and security and other special government functions;
11. To avert a serious threat to the health and safety of a person or the public at large;
12. For workers' compensation purposes and in compliance with workers' compensation laws;

(Please Print) Client Last Name_____First Name_____

13. To coroners, medical examiners and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law; and

14. If our patients are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ donation and transplantation.

Any other use or disclosure of PHI, other than those listed above, will only be made with written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **Authorization may be revoked at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

Patient Rights: Our patients have a number of rights with respect to the protection of their PHI.

CHICAGO CHRISTIAN COUNSELING CENTER will permit individuals to exercise patient rights.

The right to access copy or inspect PHI. This means our patients may come to our offices and inspect and copy most (other than Psychotherapy notes as defined in 45 CFR @ 164.501) of the medical information about them that we maintain in both paper and electronic format. We will generally permit access, copying or inspection of PHI. We will provide you with a copy of your record or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request. We may charge a reasonable fee for doing so. Information held electronically must be provided in electronic form if requested by the patient.

The right to amend PHI. Our patients have the right to ask us to amend their written medical information. We will consider amending any patients' PHI.

The right to request an accounting of our use and disclosure of an individual's PHI. Our patients may request an accounting from us of certain disclosures of their medical information that we have made in the last six years prior to the date of the request.

We are not required to give an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations.

We also are not required to give an accounting of our uses of PHI for which we already have a written authorization for such use. To request an accounting of the medical information that we have used or disclosed that is not exempted from the accounting requirement, contact the Privacy Officer listed at the end of this Notice.

The right to request that we restrict the uses and disclosures of an individual's PHI. Our patients have the right to request that we restrict how we use and disclose their medical information that we have for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in their health care. But if the information is needed to provide emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide them with emergency treatment.

Our patients have a right to a restriction to disclosure of PHI to a health plan for payment if the patient has paid in full for the services and items provided in that visit.

Revisions to the Notice: CHICAGO CHRISTIAN COUNSELING CENTER reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and posted to our website, if we maintain one. Our patients will be given a copy of the latest version of this Notice at their next visit or by contacting the Privacy Officer identified below.

Your Legal Rights and Complaints: Our patients also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services, if they believe their privacy or security rights have been violated. Complainants will not be retaliated against in any way for filing a complaint with us or to the government. Should our patients have any questions, comments or complaints they may direct all inquiries to the Privacy Officer listed below. Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact Janet Irvine, Psy.D., Licensed Clinical Psychologist and Privacy Officer for CHICAGO CHRISTIAN COUNSELING CENTER at (708) 845-5500 or (800) 361-6880, extension 108.

To complain to the Secretary of Health and Human Services please use the following information and address: HHS Regional Office, Region 5, 233 N. Michigan Ave., Suite 1300, Chicago, IL 60601, 312-886-1709

Effective Date of the Notice: August 1, 2013

I have provided my client with a copy of the above Notice of Privacy Practices.

X _____ Date: _____
Signature – Mental Health Provider

I have read and received a copy of the above Notice of Privacy Practices.

X_____ Date: _____
Signature of Recipient age 12 or over

X_____ Date: _____
Signature of Parent/Guardian of minor or guardian of a legally disabled Recipient

If the signature is not the Recipient's, indicate the legal relationship to the Recipient:_____

X_____ Date: _____
Signature - Witness

*(Please Print) Client Last Name*_____*First Name*_____