CONTACT INFORMATION & ASSESSMENT:

Name: _____ Age: _____ DOB: _____

Cell Phone	Home Phone	Work Phone
**Ok to leave VM on: Cell (Y / N)?	**Ok to leave VM on: Home (Y / N)?	**Ok to leave VM on: Work (Y / N)?

Occupation: _____ Employer: _____

Level of Education Completed: _____

Marital Status: _____ Spouse/Partner's Name: _____

Children (names/ages): _____

_____

Others living in the home: _____

_____

Emergency Contact: _____ Phone: _____

Address: _____

MEDICAL HISTORY

Do you smoke? _____ How much? _____
Do you drink? _____ How much? _____
Do you use illicit drugs? _____ What kind and how much? _____

General Practitioner Name: _____

Current medical issues: _____

List of medications & dosage: _____

_____

_____

Have you ever been hospitalized for a physical illness? Describe & include approximate dates:

_____

_____

Have you ever been diagnosed or hospitalized for mental health issues? Describe & include approximate dates:

_____

_____

Any previous therapy or counseling? _____ When/how long?_____

Please describe the type of therapy and whether it was helpful? _____

_____

_____

CURRENT ISSUES

Check any of the following that apply to you:

□Headaches
□Dizziness
□Fainting Spells
□No Appetite
□Over-Eating
□Stomach Trouble
□Bowel Disturbances
□Always Tired
□Difficulty falling asleep
□ Difficulty staying asleep
□ Unable To Relax
□Recurrent Dreams
□Nightmares
□Hallucinations

□Feeling inferior
□Feel Tense
□Feel Panicky
□Fears and Phobias
□Obsessions / Compulsions
□Depressed
□Suicidal Thoughts
□Sedative Use / Abuse
□Alcohol Use / Abuse
□Non-prescribed Drug Use / Abuse
□Allergies
□Asthma
□Trauma / Abuse History
□Sexual Problems

□Shy With People
□Can't Make Friends
□Afraid Of People
□Home Conditions Bad
□Unable To Have A Good Time
□Often Worried
□Don't Like Weekends/Vacations
□Difficulty with Decisions
□Overly-Ambitious
□Financial Problems
□Gambling
□Job Related Problems
□Can't Keep A Job
□Other (list below)

_____
_____

_____
_____

Describe presenting problems (emotional, behavioral, thoughts):_____
_____
_____
_____
_____
_____
_____

History of presenting problem: _____
_____
_____
_____
_____
_____

Life changes/stresses (job, marital, children, pregnancies/abortions, relationships, legal, financial, health, housing, losses, abuse, addictions): _____
_____
_____
_____
_____
_____
_____
_____

Other information you think I should know: _____
_____
_____
_____
_____
_____

What do you wish to achieve in therapy? _____
_____
_____
_____
_____
_____

How did you hear about my practice? _____
Is it ok for me to send a thank you note to the referral source? Yes / No

Treatment Agreement - Adult

Building a therapist-patient relationship is dependent upon trust, openness, responsibility and respect. This document contains important information about my professional services.

Confidentiality It is my goal to provide a safe and supportive environment for my patients as they participate in therapeutic services. I respect your privacy by keeping sessions confidential. Information about you is held in confidence by law and our policy is to never release information outside of sessions without your consent. Please be aware that state law and various court rulings require me to make a report to the proper authorities in one or more of the following circumstances:

- Suspected abuse, past or present, of a child under the age of 18 years.
- Suspected abuse of elders or dependent adults.
- Intention of serious and dangerous harm to self or others.
- When you waive your confidentiality. (For example, you waive your confidentiality for reimbursement purposes when using your insurance company because your insurance company requires your information for payment or reimbursement of a claim.)
- When you voluntarily use your mental or emotional state in legal proceedings.
- Following a court order. I will notify you in advance of any such disclosure so that you have the opportunity to attempt to prevent such disclosure with the court.

Electronic Communication If you choose to communicate with me by electronic means (email, text message, etc.) it is important to understand that I cannot guarantee privacy through these means. Please try to limit clinical information when using these types of communication whenever possible. Please be aware of potential risks to privacy whenever using electronic means of communication.

Scheduling and Fees The fee for psychotherapy sessions is $160 for individual sessions, $150 for parent support/family therapy and $185 for the initial evaluation. Your fee may vary depending on whether I am contracted with your insurance plan and have agreed to a different fee schedule or if you elect to self-pay. Generally sessions are scheduled on a weekly basis, or more frequently if necessary. If you need to reschedule or cancel, it is important to contact me as soon as possible so that I may attempt to find an alternative time to meet. A fee will not be charged for cancellations as long as you notify me at least 24 hours in advance. As the scheduled time is being held for you, a fee of $100 will be charged if a session is cancelled with less than 24 hours' notice or if you fail to attend a scheduled appointment. You will be charged the fee as I cannot bill your insurance for a missed appointment. It is understandable that genuine emergencies do occur and an exception will be made in those cases. If at any time phone sessions are required, please note they are not covered by insurance and will require self-pay of $100 per session.

Payment Unless your insurance plan provides for coverage, your fee is payable each session. If you have a co-pay, you will be responsible for that co-pay at each session. If you utilize your insurance benefits, we will submit billing for you to the insurance company. You will be responsible for any amount not covered by your insurance carrier. Payment can be made by cash or check.

Emergency Situations If you need to reach me between sessions, please call me directly. I will make every effort to return your call as soon as possible. In the event of a clinical emergency that needs immediate attention, please **call 911 or go to your nearest emergency room**. After one of those steps has been taken, please call me or leave me a message as soon as possible.

Substance Use Sobriety during sessions is strongly advised. Should any individual attend therapy in an intoxicated state, the session may be cancelled and may constitute a late cancellation fee.

Maintenance of Records I am required by law to maintain appropriate records related to your sessions. I will keep these records in a secure location. You have the right to a copy of your file, and you have the right to request, in writing, that these records be made available to any other healthcare provider you designate. Additional information regarding your rights with respect to your records is contained in the Notice of Privacy Practices, which has been provided to you along with this Consent.

By signing below, you indicate that you have read, understand and agree with all of the terms and conditions stated above, and that you have had the opportunity to ask questions of your therapist.

_____

Printed name

_____ _____

Signature Date

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Effective August 1, 2015

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how Meg Childress, LCSW and any clinical or administrative staff working under the supervision of Meg Childress, LCSW may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the National Association of Social Workers ("NASW") Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose health information about you

For Treatment Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical consultants or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Without Authorization Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization (except as otherwise indicated). Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state, it is my practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the National Association of Social Workers (NASW) Code of Ethics and HIPAA.

Child Abuse or Neglect We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process. We will notify you in advance of any such disclosure so that you have the opportunity to attempt to prevent such disclosure with the court or other administrative forum.

Deceased Patients We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty years is not protected under HIPAA.

Medical Emergencies We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. We will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance (such as third-party payers based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement We may disclose PHI to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm. We may also disclose your PHI in connection with workers' compensation claims.

Public Health If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research PHI may only be disclosed after a special approval process or with your authorization.

Permission We may also use or disclose your information to family members that are directly involved in your treatment with your permission.

With Authorization Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Meg Childress, LCSW at 1105 Curtiss St, Downers Grove, Illinois 60515:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with Meg Childress, LCSW. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

Right to an Accounting of Disclosures. You have the right to request an accounting of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate all reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints

If you believe that Meg Childress, LCSW has violated your privacy rights, you have the right to file a complaint in writing to Meg Childress, LCSW, 1105 Curtiss St., Downers Grove, IL 60515 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

I acknowledge that I have received and reviewed this document:

_____
Printed name

_____ _____
Signature Date

Credit Card Authorization

There are multiple payment options for your convenience. Patients typically keep a valid credit card on file which is charged on the date of service. If you prefer, you may pay in person during your appointment time. You will be charged for missed sessions and sessions that are cancelled with less than 24 hours' notice. If you accrue an unpaid balance, you will be required to keep a valid credit card on file.

I agree to the payment policy described above:

_____
Printed name

_____ _____
Signature Date

I authorize the card on file to be charged on a weekly basis for my copays, self-pay sessions, and any applicable cancelation charges.
(_____).
Initials
I authorize the card on file to be charged for my coinsurance amount and deductibles each time my insurance company processes my claims and any applicable cancelation charges.
(_____).
Initials

Credit Card:

□Visa
□MasterCard
□American Express

Name on credit card: _____

Card Number: _____

Expiration Date: _____/_____ Security Code: _____

Billing Address: _____

Email Address for credit card receipts: _____

_____
Printed name

_____ _____
Signature Date