CLIENT REGISTRATION INFORMATION

First Name _____Last Name _____
Street Address _____ City _____ State _____ Zip _____
Billing Address __ Same as above __See below
Billing Street Address _____ City _____ State _____ Zip _____
E-mail Address _____
Preferred Address for correspondence or statements ___ Billing Address ___E-mail Address
Birth Date _____ Age _____ Social Security # _____
If minor (under age 18) please write name of legal guardian_____
Employer/School_____
Employer/School Address _____ City _____State _____ Zip _____
Home Phone _____ Work
Phone_____ Cell Phone _____
How late can calls be returned? _____
Referred by_____ Relationship to insured: ___Self ___Spouse ___Child ___Other
Marital Status: ___ Single Married ___Widowed ___ Divorced ___Other
Employment Status: ____Employed ___Full-time Student ___Part-time Student

Emergency Contact Person_____ Phone Number_____

POLICY HOLDER/GUARDIAN'S INFORMATION (if different from above)

First Name _____Last Name_____
Street Address _____ City _____ State _____ Zip _____
Birth Date _____ Age _____ Social Security # _____
Employer/School_____
Home Phone _____ Work Phone _____
Caseworker's Name _____Phone _____

PRIMARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
Insured's ID # _____Group/Policy #_____ Agency/Insurance _____
Phone Insurance Claims Mailing Address _____
City _____ State _____ Zip_____
Subscriber Name _____Subscriber Date of Birth_____
Co-pay amount _____ Authorization #_____ Number of Sessions Authorized _____

Secondary Insurance ___No __Yes – Complete Secondary Insurance Information Form

A copy of your insurance card and photo ID is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Angela DeCraene, MA, LCPC and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

_____ _____
Signature of responsible party Date

SECONDARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
Insured's ID # _____Group/Policy #_____ Agency/Insurance _____
Phone Insurance Claims Mailing Address _____
City _____ State _____ Zip_____
Subscriber Name _____Subscriber Date of Birth_____
Co-pay amount _____ Authorization #_____ Number of Sessions Authorized _____

Secondary Insurance ___No __Yes – Complete Secondary Insurance Information Form

A copy of your insurance card and photo ID is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Angela DeCraene, MA, LCPC and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

_____ _____
Signature of responsible party Date

BRIEF ASSESSMENT

Please list presenting issues and length of time you have been experiencing them: _____

_____

_____

_____

_____

SYMPTOM CHECKLIST

Check all that apply

	NONE	MILD	MODERATE	SEVERE
aggressive behavior	☐	☐	☐	☐
agitation	☐	☐	☐	☐
anger	☐	☐	☐	☐
anorexia	☐	☐	☐	☐
appetite changes	☐	☐	☐	☐
believe someone is watching you	☐	☐	☐	☐
bingeing/purging	☐	☐	☐	☐
conduct problem	☐	☐	☐	☐
crying/tearful	☐	☐	☐	☐
delusions	☐	☐	☐	☐
depressed mood	☐	☐	☐	☐
difficulty getting out of bed	☐	☐	☐	☐
difficulty making decisions	☐	☐	☐	☐
dissociative states	☐	☐	☐	☐
elevated mood	☐	☐	☐	☐
fatigue/low energy	☐	☐	☐	☐
emotional trauma	☐	☐	☐	☐
feeling sadness/emptiness	☐	☐	☐	☐
general anxiety	☐	☐	☐	☐
grief	☐	☐	☐	☐
guilt	☐	☐	☐	☐
hallucinations	☐	☐	☐	☐
hearing voices	☐	☐	☐	☐
heart palpitations	☐	☐	☐	☐
hopelessness	☐	☐	☐	☐
hyperactivity	☐	☐	☐	☐
irritability	☐	☐	☐	☐
loss of energy	☐	☐	☐	☐
mood swings	☐	☐	☐	☐
need to repeat actions	☐	☐	☐	☐
obsessions/compulsions	☐	☐	☐	☐
panic attacks	☐	☐	☐	☐
phobias	☐	☐	☐	☐
post traumatic stress	☐	☐	☐	☐
poor concentration	☐	☐	☐	☐
racing thoughts	☐	☐	☐	☐
self-harming	☐	☐	☐	☐
sexual issues	☐	☐	☐	☐
sleep problems	☐	☐	☐	☐
social isolation/anxiety	☐	☐	☐	☐
substance abuse	☐	☐	☐	☐
thoughts of death	☐	☐	☐	☐
worry/anxiety	☐	☐	☐	☐
worthlessness	☐	☐	☐	☐

BRIEF HISTORY

EMOTIONAL/PSYCHIATRIC HISTORY

Have you previously had counseling services? If yes, please provide the following information:
How many visits did you have?_____ Provider Name:_____
What was the presenting issue?_____
_____

Have any of your family members been in treatment to your knowledge? If so, what was the reason(s)? _____
_____
_____

Have you previously had inpatient treatment or hospitalization for a psychiatric, emotional or substance use disorder? If yes, please provide the following information:
How many occasions? _____ How long were you hospitalized? _____
Dates: from___/___ to___/___ Facility name: _____
month/year month/year

Are you currently prescribed any psychotropic medications? If so, please provide the following information:

Medication	Dosage	Frequency	Start date	Side Effects	Beneficial?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY INFORMATION (feel free to add information below or on the back of this sheet)

Marital status?_____
Children? Please provide ages: _____
Briefly describe your relationships within your family? How do you perceive your role? _____
_____
_____
_____

Parents: Describe your present and childhood relationship with them_____
_____
_____
_____

Siblings: How many? Gender/age and describe present and childhood relationship with them:
_____
_____
_____

Other significant relationships you may like to provide information about: _____
_____
_____

Special circumstances in childhood?_____
_____
_____

Have you suffered any abuse or trauma? _____
_____
_____

SOCIO-ECONOMIC INFORMATION

Do you have an adequate living situation/home environment? _____

_____

Are you employed? Satisfied with your employment? _____

_____

Any financial or legal issues currently or historically? _____

_____

Do you have an adequate social support system? _____

_____

Any significant cultural, religious, or traditional practices? _____

_____

Any hobbies or recreational interests that are important to you? _____

_____

MEDICAL INFORMATION

Any significant medical issues that you are currently being treated for? _____

_____

Previous medical conditions? _____

_____

Are you currently prescribed any medications or therapies? _____

_____

_____

Any family members currently diagnosed with a significant illness? _____

_____

Please feel free to provide any other information that may be of importance: _____

_____

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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.
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 we may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Angela DeCraene, MA, LCPC is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Angela DeCraene, MA, LCPC is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this 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. Angela DeCraene, MA, LCPC will provide you with a copy of the revised Notice of Privacy Practices by 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 supervisors 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, 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. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order.
- 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.
  Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.
  With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

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 Angela DeCraene, MA, LCPC, 304 W. Mondamin Ave, Suite 104, Minooka, IL 60447.

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 may be 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. We may charge a reasonable, cost-based fee for copies.

- Right to Amend. If you feel that the PHI Angela DeCraene, MA, LCPC haS about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to an Accounting of Disclosures. You have the right to request an accounting of certain 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.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Angela DeCraene, MA, LCPC, 304 W. Mondamin Ave Suite 104, Minooka, IL 60447 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.

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name: _____

Date of Birth: _____/_____/_____

Social Security Number: _____-_____-_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Angela DeCraene, MA, LCPC Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Angela DeCraene, MA, LCPC at (815) 685-7601 or angela.decraene@gmail.com

Client Signature: _____

Date: _____/_____/_____

Parent, Guardian or Personal Representative Signature*:

_____

Date: _____/_____/_____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____Client Refuses to Acknowledge Receipt

Signature of Witness: _____

Date: _____/_____/_____

WHAT TO EXPECT FROM SERVICES

Hours and cancellation:
Office hours vary throughout the week. If you need to call to change an appointment time, feel free to leave a voicemail. If it becomes impossible for you keep an appointment, please be sure to cancel with more than 24 hrs notice. Appointments that have not been cancelled will be charged a $50 fee.

Fees and Insurance:
Charges for psychotherapy sessions are consistent with standard psychotherapy fees in our community. Payment is requested at time of services.

Any specific questions about youR insurance or billing can be discussed with me. Fees not paid will be sent to collections. If you have any concerns about your bill or payments, please discuss with me immediately.

Emergencies:
In the event of an emergency, you may attempt to contact me via cell phone (815) 685-7601. However, I may be in a session or not immediately available. If you are in an emergency situation, please call your local crisis line, 911, or proceed to your local emergency room.

Confidentiality:
A commitment is made to make this a safe and comfortable place for you to receive counseling services. To that end, adherence to all legal protections of your confidentiality will be assured. Limitations include life-threatening behavior, child abuse, elder abuse and judge's orders to release information. Good communication is vital so please report any problems that may arise during the course of services. Please do not hesitate to ask for clarification as needed.

I have read and agree to the above items:

_____ _____
client signature date

_____ _____
provider signature date

Authorization for Release of Confidential Health Information

I, _____, hereby authorize Angela DeCraene, LCPC
(Name of Client or Authorized Agent)
to release to/or secure from:

_____
(Name of Health Care Facility, Physician, Agency etc.)

_____
(Street Address, City, State and Zip Code)

The following information contained in the client record of
_____Born: ___/____/___
(Client's Name)

To be disclosed, the following items must specifically be checked:
O Account Information
O Office Psychotherapy Notes O Psychological Testing Report
O Treatment Summary
O Verbal Discussion of Case
O Other (specify): _____

The purpose(s) of the authorization is (are):
O At the request of the individual
O Coordination of Mental Health Treatment
O Payment of Account
O Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.
I understand that I may be responsible for the cost of medical record copying service.
I understand that this authorization is valid until it expires, unless revoked before that.
I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.
(Date)

_____ Date: ____/____/____
Signature of Client**

_____ _____
Signature of Witness Signature of Parent or Guardian

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17.