Thank you for making the decision to become part of our Evolve Therapeutic Center community. We are looking forward to getting to know you!

Before your appointment, please take some time to fill out the following packet as it will help us to gain a better understanding of how we can provide you with the support that you need. If you have a question about something in the packet, just leave it blank and talk with your therapist during your first session. We know this can be time consuming (and honestly who likes paperwork), but completion of the forms helps to maximize the time during the first appointment. Thanks for understanding and prioritizing this!

In preparation for your first time at our office here are a few helpful details: we are located at 304 W. Mondamin St, Suite 104-108, Minooka, IL. There is parallel parking directly in front of our building and a parking lot to the east of the building. We have two units but only one of our doors will be unlocked, which leads to our waiting area. When you enter our waiting room you will see that we don't have a traditional receptionist, but feel free to grab a water, cup of tea or coffee, and flip through a book or magazine while you wait. Your clinician will be out to greet you at your appointment time.

If you need to utilize the restroom before your appointment, enter the hallway through the waiting area, take a left and then a right. There is a sign on a door towards the back of the office signaling the restrooms. The bathrooms are in a shared hallway with the rest of the building. There are other appointments going on, so we ask that you keep this in mind, but if you get turned around please feel free to ask anyone you see for help.

We strive to make our space comfortable for everyone. Thank you again for choosing Evolve Therapeutic Center. We look forward to working with you!

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"), Evolve Therapeutic Center 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. Evolve Therapeutic Center 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. Evolve Therapeutic Center 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, Evolve Therapeutic Center PO Box 608 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 Evolve Therapeutic Center 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, Evolve Therapeutic Center PO Box 608, 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 Evolve Therapeutic Center Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Evolve Therapeutic Center (815) 274-7308 or evolvetherapeuticcenter@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 SERVICE

HOURS AND CANCELATION:

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 to keep an appointment, please be sure to cancel with more than 24 hours notice. Appointments that have not been canceled within 24 hours will be charged a $75 fee.

FEES AND INSURANCE:

Charges for psychotherapy sessions are consistent with standard psychotherapy fees in our community. Payment is requested at the time of services. Our office will ask you to keep a credit card on file.

Any specific questions about your insurance or billing can be discussed with your clinician. 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 your clinician via cell phone. However, we may be in 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 behaviors, 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

SOCIAL MEDIA:

It is our policy to not accept a friend request (or similar virtual relationship that uses another term) or send a friend request, on any social media platform, from current clients or in any case believed to blur the counselor-client relationship in an adverse way. Additionally, all counselors will respect the privacy of their clients' presence on social media and will not view such information without given consent. This includes (but not limited to) the following social networking platforms: Facebook, Twitter, Instagram, Linked-In, Group Me.

I have read and agree to the above items:

Client Signature Date

Provider Signature Date

CLIENT REGISTRATION INFORMATION

First Name _____Last Name _____
Street Address _____ City _____State _____ Zip _____
Billing Address ( ) Same as above ( ) See below
Street Address _____ City _____State _____ Zip _____
E-mail Address _____
Preferred Method 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_____
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 Information Phone Number_____
Agency/Insurance Claims Mailing Address _____
City _____ State _____ Zip_____
Subscriber Name _____Subscriber Date of Birth_____
Co-pay amount _____ Authorization #_____
Number of Sessions Authorized _____

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 Evolve Therapeutic Center 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 be 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

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 Evolve Therapeutic Center 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 be responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or canceled 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 INSURANCE AGREEMENT

I understand that Evolve Therapeutic Center will not submit my claims to my secondary insurance provider. If my primary and secondary insurance policies are set up to connect and communicate with each other automatically and payment is received, then the secondary payment will be accepted. However, Evolve will not manually submit to my secondary provider. In some cases, Evolve is not in network with the secondary insurance provider (such as medicaid) and in other cases the manual process for submission is unreliable. I can request a statement at any time which will have accurate and up to date information about my account and I can choose to submit this statement along with my estimate of benefits to my secondary provider in order to request payment. However, I will be responsible for paying whatever my primary policy does not cover.

_____

Client Signature Date

_____

Witness Signature Date

What are the primary reasons you are seeking counseling?

1._____
2._____
3._____

Have you previously seen a counselor or therapist? ( ) Yes ( ) No

If yes, what did you find the most helpful in therapy? What did you find the least helpful in therapy?

_____

_____

_____

_____

If yes, what were your therapy goals? Were the goals successfully met?

_____

_____

_____

Are you or have you ever been mandated to receive therapy, attend group or individual counseling? ( ) Yes ( ) No

Do you have a current or previous mental health diagnosis? If so, what is the diagnosis, what professional provided the diagnosis and when?

_____

_____

Are you interested in the additional support of a certified life coach? ( ) Yes ( ) No

_____

Relationship History and Current Family

Are you currently:

( ) Married ( ) Partnered ( ) Divorce ( ) Single ( ) Widowed ( ) Other How long?_____
If not married, are you currently in a relationship?
( ) Yes ( ) No

How would you identify your sexual orientation?
( ) Heterosexual ( ) Homosexual ( ) Bisexual ( )Transsexual ( )Unsure/questioning ( ) Asexual ( ) Other ( ) Prefer not to answer

What is your spouse or significant other's occupation?_____

How is your relationship with your spouse or significant other?
( ) Very good ( ) Good ( ) Moderate ( ) Poor

Have you had any prior marriages? ( ) Yes ( ) No

Do you have children? ( ) Yes ( ) No
How is your relationship with your children?
( ) Very good ( ) Good ( ) Moderate ( ) Poor

List everyone that currently lives with you:

_____

_____

_____

_____

Occupational and Educational History

Highest educational level or degree obtained:_____

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired How long in

current position?_____

What is/was your occupation? _____

Where do you work? _____

Are you satisfied with your current position? ( ) Yes ( ) No
Have you ever served in the military? ( ) Yes ( ) No
If so, what branch and when? _____
Honorable discharge? ( ) Yes ( ) No

Legal History

Have you ever been arrested? ( ) Yes ( ) No
Do you have any pending legal problems? ( ) Yes ( ) No

Spiritual Life

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No If yes, what is your level of involvement: _____ Is your involvement something you would like to discuss?
( ) Yes ( ) No

Medical

Do you have any concerns about your physical health that you would like to discuss with us?
( ) Yes ( ) No

Explain:

_____

_____

Do you have a history of serious injury that you would like to discuss with us? ( ) Yes ( ) No

Explain:

_____

_____

Do you have any allergies? ( ) Yes ( ) No

_____

Have you had a life threatening allergic reaction? ( ) Yes ( ) N
Explain:_____

_____

How would you rate your quality of sleep? Please describe any or all concerns.
( ) Very good ( ) Good ( ) Moderate ( ) Poor

Do you exercise regularly?
( ) Yes ( ) No
Frequency and duration of exercise: _____
Preferred type of exercise: _____

How would you rate your understanding between your diet and nutrition on the impact of your mental health (gut-brain health)?
( ) Very good ( ) Good ( ) Moderate ( ) Poor
Is this something you would like to discuss more?
( ) Yes ( ) No

Past Psychiatric History

Do you currently or have you ever taken any medication for psychiatric or behavior problems?
( ) Yes ( ) No

Name	Dose	Reason	Result/Effect	Current/Past

Outpatient Treatment ( ) Yes ( ) No
If yes, please describe when, by whom, and the nature of the treatment.

Reason	Dates Treated	Where

Inpatient Psychiatric Hospitalization ( ) Yes ( ) No
If yes, please describe when, where, and the nature of the treatment.

Reason	Dates Treated	Where

Chemical Use and History

Do you currently use alcohol? ( ) Yes ( ) No
If yes, how often do you drink?
( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
If yes, how much do you drink? _____ (number of drinks per time)
Do you currently use tobacco? ( ) Yes ( ) No
If yes, how often do you smoke/chew?
( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
Do you currently use any other drugs? ( ) Yes ( ) No
If yes, what drugs do you use? _____
If yes, how often do you use?
( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
Have you ever received treatment for drug or alcohol use?
( ) Yes ( ) No
If yes, where was treatment?_____
( ) Outpatient ( ) Inpatient

Assessment of Risk For Suicide or Homicide

Have you ever had the feelings or thoughts that you didn't want to live? ( ) Yes ( ) No If yes, please answer the following. If no, please skip to the next section.
Do you currently feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts?
( ) Daily ( ) Weekly ( ) Occasionally ( ) Rarely
When was the last time you had thoughts of dying?_____
Have you ever had thoughts about how you would kill yourself? ( ) Yes ( ) No Is the method you would use readily available? ( ) Yes ( ) No
Do you have a history of suicidal attempts? ( ) Yes ( ) No
Is there a history of suicide among your family? ( ) Yes ( ) No ( ) Unsure Are there currently any weapons in your home? ( ) Yes ( ) No
If yes, where are they located in the home and what safety precautions are put in place?

_____

_____

History of Physical or Sexual Abuse

Have you experienced abuse? ( ) Yes ( ) No

If yes, what type of abuse:

( ) Physical ( ) Verbal ( ) Sexual ( ) Neglect

If yes, if you feel comfortable please explain:

_____

_____

_____

_____

Individual Concerns

Symptom	None	Mild	Moderate	Severe	Frequency
Sadness					
Crying					
Sleep Disturbances					
Dissociation					
Hyperactivity					
Binging					
Purging					
Unresolved Guilt					
Irritability					
Nausea					

Symptom	None	Mild	Moderate	Severe	Frequency
Social Anxiety					
Self Harm					
Impulsivity					
Nightmares					
Hopelessness					
Elevated Mood					
Mood Swings					
Disorganized					
Anorexia					
Social Isolation					
Phobia					
Obsessive Thoughts					
Grief					
Loneliness					
Appetite Change					
Paranoid Thoughts					
Poor Concentration					
Indecisiveness					
Low Energy					
Excessive Worrying					
Low Self Worth					
Anger Issues					
Hallucinations					
Racing Thoughts					

Restlessness					
Drug Use					
Alcohol Use					
Easily Distracted					
Trauma Flashbacks					
Work Issues					
Problems at Home					
Panic Attacks					

Symptom	None	Mild	Moderate	Severe	Frequency
Feeling Anxious					
Feeling Panicky					
Suicidal Thoughts					
Other:					
	Yes	**No**			
Abuse Past					
Abuse Present					

Complete the following if intake client is under the age of 18 years old

Family Data

Father

Name: _____

Address:_____

Phone Number:_____

Place of Employment:_____

Mother

Name:_____

Address:_____

Phone Number:_____
Place of Employment:_____

Step-father
Name: _____
Address:_____
Phone Number:_____
Place of Employment:_____

Step-mother
Name: _____
Address:_____
Phone Number:_____

Place of Employment:_____

Who does the client reside with? _____

List on this page in chronological order the names of all children, including the client, siblings, step brothers, sisters, half brothers and sisters, and any miscarriages and stillbirths.

Name Relationship to client Sex DOB Type of relationship with client

_____

_____

_____

_____

_____

Please check any family concerns that your family is currently experiencing

( )Fighting
( ) Feeling distant
( ) Loss of fun
( ) Lack of honesty
( ) Physical fights
( ) Education problems
( ) Financial problems
( ) Death of a family member
( )Abuse/neglect
( ) Inadequate housing/feeling unsafe
( ) Job change or job dissatisfaction
( ) Disagreeing about relatives
( ) Disagreeing about friends
( ) Alcohol use
( ) Drug use

( ) Infidelity
( ) Divorce/separation
( ) Remarriage
( ) Birth of a sibling

Developmental Information:

Length of Pregnancy:_____ Birth Weight:_____

Was the pregnancy complicated or involved with drugs or alcohol?_____
Nature of delivery: ( ) Natural ( ) Caesarian ( ) Breech

Condition of child at birth:_____

Was the child adopted? ( ) Yes ( ) No

Were there any developmental milestones that the child was delayed in? If so, please describe intervention, if any, that was provided.

_____

_____

What have the significant stressors or traumas been to the family and child?

_____

_____

_____

Educational History

Current school placement:_____
Previous school placements:_____
Current grade level: _____
Does the client have an active 504 or IEP? ( ) Yes ( ) No
*Please provide a copy of plan to clinician
Has your child previously had a 504 or IEP in place? ( ) Yes ( ) No Does your child receive social work support at school? ( ) Yes ( ) No What other learning or emotional support does the child receive in school?

_____

_____

What comments have your child's teacher shared with you in the past about your child in the classroom setting?

_____

_____

Has your child ever refused to go to school? ( ) Yes ( ) No

Explain:_____

_____

_____

_____

Social History

Does your child prefer to play alone or with others:_____

Does your child have close friends: ( ) Yes ( ) No ( ) Not sure

What are your child's hobbies: _____
Does your child get picked on or teased: ( ) Yes ( ) No ( ) Not sure Does your child make negative statements about him/herself? ( ) Yes ( ) No ( ) Not sure

Please mark all that apply:

( ) Inappropriate expression of feelings
( ) Concern people are out to get him/her
( ) Social withdrawal
( ) Pessimistic outlook toward the future
( ) Excessive tearfulness or crying
( ) Concerns about sexual identity
( ) Sexually promiscuous
( ) Poor relationship with parents
( ) Sibling rivalry
( ) Argues, brags, boasts
( ) Mean to others
( ) Has difficulty making/keeping friends
( ) Does not associate with people his or her own age
( ) Avoids unfamiliar social situations
( ) Is easily led by others
( ) Poor personal hygiene
( ) Enuretic (urinated during the day or night self)
( ) Encopretic (soils self)
( ) Deliberately harms self
( ) Tics

ClinicianUseOnly:

Client Name: _____

Name on Card (if different): _____

I authorize Evolve Therapeutic Center to charge my credit/debit card for professional services as follows:

❏ This visit only, for the amount of $ _____.

❏ All visits in the next 12 months, beginning _____/_____ /_____, not to exceed $ _____ total.

❏ Recurring charges, date(s) of service _____ /_____ /_____ to **_____ /_____ /_____,** not to exceed $_____,

❏ ____ monthly, ____ semimonthly, ____ weekly, ____ per visit.

To charge my card for the balance of fees not paid by my insurance company within 90 days, as indicated above.

Type of Card:_____

Card Number _____ - _____ - _____ - _____

CVV Number _____Expiration Date _____

Card Holder's Billing Address for Credit Card Statements

_____

Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact my provider. I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

Card Holder Signature _____

Date