INTOUCH & MOTION

3806 W. Irving Park Rd. #Store, Chicago IL, 60618 | 773-850-9046 | info@intouchandmotion.com

Client Intake Form

CLIENT INFORMATION

First Name _____ Middle Int._____ Last Name _____

○F ○M DOB: ____/____/_____ Marital Status: Single Married Other

Cell Ph:(___) _____ Home Ph:(___) _____ Email:_____

Street Address:_____City: _____

State:_____ Zip:_____ Preferred form of contact: Phone Email

Parent/Guardian (if client under 18):_____Relationship: _____

(*If different than client, complete below)*

Cell Ph:(___) _____ Home Ph:(___) _____ Email: _____

Street Address:_____City: _____

State:_____ Zip:_____ Preferred form of contact: Phone Email

Emergency Contact:_____ Relationship: _____

Cell Ph:(___) _____ Home Ph:(___) _____

BILLING INFORMATION

Please provide a copy of: ○ INSURANCE CARD ○ LICENSE or ID

Bill my insurance: Yes No Insurance Company: _____

Insured's Name:_____Relationship: _____

DOB:_____/____/ _____ Insured's SSN: _____

ID/Policy #_____Group# _____

Insured's Employer: _____ Work Ph:(___) _____

Billing address same as the client: Yes No (*If different than client, complete below)*

Street Address:_____City: _____

State:_____ Zip:_____

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Practice Policies and Informed Consent

Please read this document carefully, as it includes important information about our practice policies and services. Feel free to ask any questions you may have. Once signed, this will constitute a binding agreement between you and your psychotherapist.

Psychological Services

Psychotherapy and the approach to treatment may vary depending on the personality of both the psychotherapist and the client(s), the age of the client(s), and the problem being presented. Therapy with children may be a slower process than with adults because it takes a child longer to become comfortable in the environment and trusting of the psychotherapist. There are a number of different approaches that can be utilized to focus on presenting problems, including a combination of talk therapy, play therapy, dance/movement therapy, and/or other creative modalities to support the client(s) in working through problems and expressing needs and feelings. Psychotherapy also requires active effort on the client(s) part. To be most successful, client(s) will be asked to work on things during sessions and at home.

Psychotherapy has both risks and benefits. Risks often include experiencing uncomfortable feelings or a temporary increase in targeted negative behaviors. Psychotherapy has also been shown to have significant benefits including a reduction in feelings of distress, improved relationships, decrease in negative behaviors, and resolution of specific problems. However, there are no guarantees about what or when changes will occur.

The first few sessions will involve an assessment and evaluation of the client(s) needs. By the end of the evaluation, the psychotherapist will offer the client(s) impressions of what the work will include and an initial treatment plan. Client(s) are encouraged to discuss questions or these procedures and purpose of treatment with the psychotherapist before proceeding with therapy.

With children, the first few sessions may involve a combination of meetings with the parents/guardians and child both individually and as a family. Parents/guardians will be provided an overview of the progress and continued areas of focus for the child. As well, the child will be encouraged to share concerns and feelings with the parents/guardians through engagement in family therapy. Specific information shared by the client during the therapeutic process will not be shared with the parents/guardians unless the psychotherapist is concerned for the child's well-being or if it is believed that sharing the information will benefit the therapeutic process. However, client(s) under 18 years of age, please be aware that the law may provide parents/guardians the right to examine your treatment records.

Confidentiality & Emergency Situations

In general, the law protects the confidentiality of all communications between a client and their therapist. Exceptions to confidentiality include (a) information about abuse or neglect of a child or elderly person (your psychotherapist is required by law to report this to the Illinois Department of Children and Family Services); (b) information shared with your insurance company to process claims; (c) the client(s) sign a release to have specific information shared; (d) if information is provided that suggests the client(s) is in danger of hurting themselves or others. If an emergency arises for which the client(s) or parent/guardian feels immediate attention is necessary, the client(s) and parent/guardian understand they are to contact emergency services directly. Please see the "Notice of Privacy Practices" for further details.

I have read and understand my confidentiality rights.

Client Name: _____ Signature _____ Date _____

Parent/Guardian Or Spouse/Partner Name: _____ Signature _____ Date _____

Psychotherapist Name: _____ Signature _____ Date _____

Fees and Insurance

Client(s) are expected to pay at the time of service unless an alternate arrangement with your psychotherapist has been made in advance. The fee for the initial assessment session is $_____. Ongoing sessions are $_____. When using insurance for payment, if your psychotherapist is in your network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with the insurance company. Your psychotherapist may not charge you the difference between the fees listed above and the agreed upon usual and customary rate, beyond the co-pay required by your insurance.

In addition to your regular appointments, it is our practice to charge $25/15 minutes for other professional services that exceed 15 minutes, such as report writing, telephone conversations, attendance at meetings or consultations with other professionals that you have authorized, preparation of records or treatment summaries, or the time required to perform any other service that you may request of your psychotherapist. If you become involved in litigation that requires our participation, you will be expected to pay for the professional time required at an hourly rate of $500/hour plus traveling expenses for preparation for and attendance at any legal proceedings. Please discuss this with your psychotherapist prior to initiating Amanda E. Mitchell Therapy Services, LLC in any legal proceedings.

If using medical insurance, the client(s) are responsible for services not covered by the insurance, including, but not limited to, copayments, coinsurance, and noncovered or ineligible services, as well as all charges for services provided over the maximum allowable benefit for the calendar year. **If the client(s)' insurance company denies payment, the client(s) are responsible for the payment. Client(s) who change insurance companies must notify their psychotherapist immediately.** A change of insurance may mean that the client(s) may no longer be covered and therefore responsible for payment.

Your cooperation is appreciated. If at any time you have any questions regarding insurance, fees, balances, or payments, please feel free to ask.

Cancellation & Rescheduling Policy

Client(s) are expected to give their psychotherapist 24 hour notice to cancel or reschedule an appointment. Failure to give 24 hours notice will result in a full fee for the canceled session.

Contacting Your Psychotherapist

Client(s) may leave voice messages for their psychotherapist at any time. Your psychotherapist will make every effort to return your call within 24 hours with the exception of weekends, holidays, or when out of town. If you cannot reach your psychotherapist and you feel that it is imperative that you speak with someone, you should call your family physician, 911, or the emergency room at the nearest hospital and ask for the psychiatrist or psychologist on call.

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Email, Voicemail, and Text Message Communication

E-mail is not a secure form of communication and confidentiality of any e-mailed information cannot be ensured. It is your choice if email is to be used to correspond with you and/or a designated party for the purpose of scheduling appointments, conveying information about your treatment or the treatment of your child or records you specifically request (e.g., diagnostic reports). Please be advised that e-mail is not to be used in order to communicate urgent matters or emergencies. Please ***initial*** below if you do or do not grant permission for email communication:

_____ YES - By initialing this box to the left, I am granting consent for my mental health care provider to communicate via e-mail. I understand that because email is not a secure form of communication, confidentiality cannot be ensured of any information sent via email.
_____ NO - By initialing this box to the left, I am indicating that I DO NOT grant permission for email communication as described above.

Similarly, confidentiality cannot be guaranteed on insecure voicemail or text messaging. Text messaging communication with client(s) is limited to information about appointments, such as verifying appointment time or notifying your psychotherapist when running late. Please call or email for more involved communication. Please initial below if you do or do not grant permission to leave voicemail messages.

_____ YES – My psychotherapist may leave a message on client(s) voicemail confirming appointments and/or information requested regarding client(s) treatment.
_____ NO – My psychotherapist may not leave messages on client(s) voicemail.

Newsletters and Practice Updates

_____YES – I would like to receive newsletters and practice updates by mail and email.
_____ NO – I would not like to receive newsletters and practice updates by mail and email.

Social Media

InTouch & Motion is present in social media, such as Facebook. Social media may be used to disseminate information, but confidentiality of client(s) is taken very seriously and your psychotherapist will not engage in social networking with client(s). You are welcome to like or follow us, but we will not respond to any comments.

My signature below indicates my consent to Treatment and understanding of Practice Policies.

Client Name: _____ Signature _____ Date _____

Parent/Guardian Or Spouse/Partner Name: _____ Signature _____ Date _____

Psychotherapist Name: _____ Signature _____ Date _____

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Consent to Release Information for Processing Benefits

I hereby authorize InTouch & Motion to release any of the following requested information for the purpose of obtaining reimbursement of treatment services provided directly to my dependents or me. Information may include: Admitting Diagnosis; Final Diagnosis; Discharge Summary; Designated clinical records (e.g., treatment plans, progress notes, etc.)

Information may be released to any or all of the following as needed: Any third party payer having responsibility for payment of charges for treatment; Review agents/auditors; Managed Care agents.

This consent is valid until such time that all claims have been settled to the satisfaction of InTouch & Motion or up to one year from the date of discharge from treatment, whichever is longer.

I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize InTouch & Motion to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent any time before the expiration date so long as I submit my revocation in writing to this office. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent, I hereby assign, transfer, and set over to InTouch & Motion all of my rights, title, and interest to reimbursement benefits under my insurance policy(s), including any and all major medical benefits. I understand that I am financially responsible to InTouch & Motion for charges not covered by this assignment.

Client Name: _____ Signature _____ Date _____

Parent/Guardian Or Spouse/Partner Name: _____ Signature _____ Date _____

Psychotherapist Name: _____ Signature _____ Date _____

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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 carefully.

Commitment to Your Confidentiality and Privacy

InTouch & Motion, is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our client(s)' personal information. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession. We are required by law to keep your information private and to provide you this notice, which describes policies related to the use and disclosure of your healthcare information, your rights and our responsibilities. We will review this information together at your first session.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services, and for other healthcare operations that are necessary to provide you quality care. Please review the following information about the possible uses and disclosures of your health information for the purpose of providing services.

Treatment

We may need to use or disclose (send, share, release) health information about you to provide, manage or coordinate your care and related services. This may include communications with consultants, potential referral sources, etc. In all cases, this requires your written consent, including a signed Authorization for Release of Information Form.

Payment and Billing

InTouch & Motion, may need to use or disclose health information about you in order to verify insurance coverage and/or benefits with your insurance carrier to process claims as well as information needed for billing and collection purposes. If you are using a family insurance plan, we may bill the "insured" person in your family who pays for your insurance, as you listed them on your client intake form. Please see the "Consent to Release Information for Processing Benefits" form for further details. We also utilize an electronic billing service to process claims via the internet that is in compliance with HIPAA security regulations and processing standards.

Healthcare Operations

In order to review our treatment procedures and business activity, and complete certification, compliance, and licensing activities, we may use information about you. Identifying information about you will not be disclosed without explicit written consent.

Disclosures without Consent

Of course we will keep your health information private, but there are uses and disclosures of your information that do not require your consent as well as times when the law requires us to use or share it.

This may include

- **Emergencies**. Information will be shared to address an immediate emergency.
- **Public Health Activity**. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat, as well as alert any other person who may be in danger.
- **Criminal Activity**. We may disclose health information about you if a crime is committed on our premises or against our personnel or associates, or if we believe someone is in immediate danger.
- **Child/Elder Abuse**. By state law, we are required to report information about you that may be related to the suspicion of child and/or elder abuse or neglect.
- **Judicial and Administrative Proceedings.** We may disclose personal health information in relation to some lawsuits and legal or court proceedings in response to a valid court order or other lawful process.
- **National Security, Intelligence Activities.** As authorized by law and in cases of national security, we may release health information about you to authorized federal officials.
- **Workers Compensation.** Workers Compensation claims and similar benefit programs may require us to disclose personal health information.
- **Business Associates.** Amanda E. Mitchell Therapy Services, LLC, may disclose minimum necessary health information to business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All business associates sign confidentiality agreements to protect the privacy of information and are not allowed to disclose information other than what is specified in our contract.

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Your Rights Regarding Your Health Information

1. **Right to Receive Appropriate Treatment.** We strive to offer treatment that is appropriate and helpful, and you have the right to terminate treatment if you are not satisfied.
2. **Right to Request How We Contact You**. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
3. **Right to Release Your Medical Records.** You may complete an Authorization for the Release of Information form if you wish your records to be released to another provider. You have the right to revoke this authorization in writing at anytime, with the exception of any communications made prior to the revocation.
4. **Right to See and Copy Your Records.** You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records. A fee may be associated with this service. Your request must be in writing.
5. **Right to Correct Your Medical Records.** If you believe the information in your record is incorrect or missing important information, you can ask us to make changes (called amending) to your health information. You must make this request in writing to your psychotherapist. In your request, you must tell us the reason(s) you want to make the changes. We have the right to deny your request under certain circumstances and we'll tell you why in writing within 60 days.
6. **Right to Limit What We Use or Share.** You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. You may request that we not share information with your insurance company, in which case you would be responsible to pay in full for the services provided. You must make your request in writing. While we do not have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
7. **Right to be Notified of a Breach in Confidentiality.** We make every effort to maintain security of confidential information at all times. It is unlikely that a breach will occur, but in such case you will be promptly notified.
8. **Right to a Copy of this Notice and Changes in Policy**. If we change the Notice of Privacy Practices we will notify you as soon as possible. A copy can be provide upon request.
9. **Ask Questions or File a Complaint**. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the InTouch & Motion Founder, Amanda Mitchell LCPC BC-DMT, and she may be contacted at 773-850-9046 or at amanda@intouchandmotion.com. If you are not satisfied with the response to your complaint, you may file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov/ocr/hippa/. All complaints must be in writing. Filing a complaint will not change the health care we provide to you, and we will not retaliate in any way.

To Submit any written requests or to discuss privacy practices and your rights regarding your health information in more detail, please contact Amanda E. Mitchell, LCPC, BC-DMT at 773-850-9046 or amanda@intouchandmotion.com. The effective date of this Notice is July 31, 2017.

Acknowledgement of Notice of Privacy Practices

I, hereby acknowledge receipt of InTouch & Motion "Notice of Privacy Practices". The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information in accordance with HIPAA (Health Insurance Portability and Accountability Act). I understand that InTouch & Motion has reserved the right to change its privacy practices that are described in the notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

Client Name: _____ Signature _____ Date _____

Parent/Guardian Or Spouse/Partner Name: _____ Signature _____ Date _____

Psychotherapist Name: _____ Signature _____ Date _____