LifeBalance counseling

1375 Remington Rd, Suite K Schaumburg, IL 60173	509 Old Northwest Hwy, Suite 210F Barrington, IL 60010	IS132 Summit Ave, Suite 207B, 305A/B Oak Brook Terrace, IL 60181

888.234.7628
info@lbcounseling.com

CLIENT INTAKE FORM

Date: _____/____/ _____

GENERAL INFORMATION

Client's Last Name: _____First Name: _____ MI _____

Guardian/Parent(s) (if under 18): _____

Client's Date of Birth: _____/_____/_____

Address: _____ City: _____

State:_____ Zip: _____

Phone: (House)_____(Cell)_____(Work)_____ (Email)_____

May Life Balance Counseling communicate with you via SMS text messages and emails regarding your appointments, treatment, and other related information?

□ YES. And I understand and acknowledge that there may be risks associated with sending information in an unencrypted email or text message such that the information may be read by an unintended third party; however, Life Balance Counseling ensures that it take steps to send only limited information to you via email and text.

□ NO. I do not wish to be contacted by SMS text message or email.

How were you referred to Life Balance Counseling? □ Insurance □ EAP □ School □ Friend □ Psychology Today

□ Good Therapy □ Yelp □ Physician _____ □ Other _____

EMPLOYMENT/EDUCATION

Current Place of Employment: _____

Job Title: _____

Number of months/years at current job: _____

Highest education completed: □ High school/GED □ Some college □ College Graduate/other

Current Grade in School (Children and Adolescents Only): _____ School: _____

FAMILY INFORMATION

Relationship Status: □ Single □ Engaged □ Married □ Separated □ Divorced □ Widowed

If you have children or siblings, please list their names and ages:

Name: _____ Age: _____ Name: _____ Age: _____
Name: _____ Age: _____ Name: _____ Age: _____

Emergency Contact (Name/Phone/Relationship to you):

_____

MEDICAL/PSYCHOLOGICAL HISTORY

Date of last physical: _____/____/ _____

Are you experiencing any physical illnesses or symptoms at this time?

_____

List any major surgeries or illnesses:

_____

List current medication(s) and dosage(s):

_____

Have you received psychotherapy or counseling in the past? □ Yes □ No If yes, when _____

Name of therapist: _____

Name of agency: _____

Have you ever been on any psychiatric medication? □ Yes □ No If yes, when? _____

Name of medication(s) and dosage(s):

_____

Name of psychiatrist: _____ Name of agency: _____

CONSENT TO RELEASE INFORMATION TO OTHER MEDICAL PROFESSIONALS

□ I hereby give my consent to communicate with my own or my child's Primary Care Physician (PCP) or other relevant health care provider about treatment.

OR

□ I choose to refuse permission and do not prefer to have any other medical providers contacted regarding my care at Life Balance Counseling.

If consent is provided, please complete below.

Primary Care Physician or other Health Care Provider:

Name: _____Address: _____

Phone: _____Email: _____Specialty: _____

Client Signature: _____ Date: _____
(*Client 12 & over)*

Parent/Guardian Signature: _____ Date: _____

CURRENT SYMPTOMS

What is your reason for seeking counseling now? _____

Please check any of the following symptoms/conditions you or your child is experiencing at this time:

□ Suicidal thoughts □ Fatigue □ Sadness □ Anxiety □ Racing thoughts □ Irritability □ Poor appetite □ Difficulty sleeping □ Weight loss/gain □ Rapid Heart beat □ Dizziness □ Stomach trouble □ Headaches □ Sexual, physical, emotional abuse □ Self-injury □ Mood instability □ Parenting issues	□ Sleep disturbances □ Learning difficulties □ Self-esteem □ Co-dependency □ Hyperactivity □ Impulsivity □ Loss of hope □ Anger □ Poor concentration □ Stress □ Loneliness □ Nightmares □ Muscle tension □ Too much energy □ Flashbacks □ Frequent worrying □ Work/job problems	□ Financial issues □ School problems □ Domestic Violence □ Substance use/abuse (self) □ Substance use/abuse (family or friend) □ Partner relationship issues □ Coping with divorce □ Grief and loss □ Sexual problems □ Others (List) _____ __ _____ __ _____ __

What would you like to see happen as a result of counseling?

_____

_____

_____

_____

BILLING & INSURANCE INFORMATION

Will you be using insurance? □ Yes □ No Full fee: □ Yes □ No Sliding scale: □ Yes □ No

Insurance Company: _____ID#: _____

Group#: _____ Provider Services phone #: _____

Subscriber Relationship to Client: □ Self □ Spouse □ Parent (Please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/_____

Address of Subscriber (If different than above):

_____

City: _____ State: _____ Zip: _____

SECONDARY INSURANCE (if applicable)

Insurance Company: _____ ID#: _____

Group#: _____ Provider Services phone #: _____

Subscriber Relationship to Client: □ Self □ Spouse □ Parent (Please complete below if other than self)

Subscriber Name: _____ Subscriber's Date of Birth: ____/____/_____

Address of Subscriber (If different than above): _____

City: _____ State: _____ Zip: _____

CLIENT OR AUTHORIZED PERSON'S SIGNATURE

• I authorize the release of any medical or other information necessary to process this claim.

• I authorize payment of medical benefits to Life Balance Counseling, Inc. for services rendered.

• **I accept the financial responsibility of any balance remaining on my account after my insurance company has processed the claim.**

Signature _____ Date: _____/____/ _____

CANCELLATION & RETURNED CHECK POLICIES

• Due to the nature of counseling services, we never overbook our schedules; therefore, we request 24-hour notification of cancellation so that others may utilize that time. As a result, we charge a **$75 cancellation fee** when we do not receive this notice within 24 hours of your scheduled appointment time. Insurance companies will not cover payment for missed appointments. Full payment for the missed session is due within one week.

• There will be a $25 services charge on all returned checks.

Signature _____ Date: _____/____/ _____

CREDIT CARD AUTHORIZATION

The undersigned agrees and authorizes Life Balance Counseling, Inc. to charge the credit card indicated below for any account balances which include, but are not limited to, deductible, co-pay, coinsurance, and fees for late cancel and no-show appointments.

Client's Name:_____ Name as it Appears on the Credit Card: _____

Card Number: _____ Exp. Date: (month/year) ____/ _____

Security Code:_____

Signature _____ Today's Date: _____/____/ _____

CREDIT CARD ON FILE POLICY

All clients are required to keep a credit card on file with Life Balance Counseling in order to receive services. Clients are required to pay any fees due at the time of service and are welcome to pay balances due from monthly statements in person, by mail, by phone, or by credit card on file. Your credit card will be securely stored on file to charge your card after each session for all copays, and for all non-covered service charges, co-insurances, deductibles, monthly balances, payment plan agreements, sliding scale agreements and any other accrued charges.

Signature _____ Today's Date: _____/____/ _____

INFORMED CONSENT

SERVICES OFFERED

Life Balance Counseling, Inc., provides outpatient-counseling services. We work with children, adolescents, adults, couples and families. Licensed counselors provide individual, group, couples, and family counseling. Psychiatric services can be arranged through a referral by the counselor.

We strive to return all messages as quickly as possible Monday through Friday. Routine messages left on the weekend may be returned Monday. We do not guarantee 24-hour crisis coverage and if your therapist is not available when you feel you are in crisis, please call the 24/7 Crisis line at 866-427-4747, proceed to your local hospital emergency room, and/or call 911.

INITIAL ASSESSMENT, DIAGNOSIS, AND COUNSELING PROCESS

Initial assessments take place at the first appointment. These appointments are used to complete necessary paperwork, gather information, and to determine a treatment plan. A diagnosis will be given for each client being seen, just as with a visit to a medical doctor. Employers, insurance companies, and schools are permitted to inquire as to whether an individual has ever been diagnosed with certain mental health conditions. The counselors' obligation is to act in accordance with ethical standardized diagnostic coding procedures.

If ongoing counseling is recommended, we will establish a treatment plan and provide evidence-based therapeutic methods and tools as part of the treatment. Your commitment to the counseling process is essential in order for treatment to be effective. This includes regular attendance and active participation, homework between sessions to enhance or speed up your growth, and completion of the process through planned termination of counseling services.

FEES

I hereby agree to full responsibility for all counseling service fees incurred by the client named below and agree to the full extent of my financial obligation to Life Balance Counseling, Inc. I have read and agree to the counseling service fees stated below. Please see our table below that describes our counseling service fees.

Description	Fee For Service	Insurance Billable
Initial Intake Assessment	$185.00	✓
Individual Counseling Session (50-60 minutes)	$150.00	✓
Individual Counseling Session (45 minutes)	$130.00	✓
Couples or Family Counseling Session (50-60 minutes)	$165.00	✓
Cancelled/Missed Session (Less then 24 hr notice)	$75.00	Not Billable to Insurance
Phone Calls, Letters, & Reports (5-15 minutes)	$30.00	Not Billable to Insurance
Court Appearances (45-50 minutes)	$250.00	Not Billable to Insurance

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed within one week, and an alternate method of payment is required. If your account is 90 days past due, you will be forwarded to a collection agency and will be responsible for a 25% fee for the total amount submitted to collections. Continued non-payment will result in a report to the credit bureau and unpaid balances will remain on your credit report until payment is received in full.

INSURANCE

We bill most insurance companies as a courtesy to you. When billing insurance on your behalf, insurance payments will be issued to Life Balance Counseling, Inc. If we are not able to work with your insurance company, we will request payment in full and provide you the necessary information to submit your own claim. If benefits have already been verified, you will find this information on the attached Benefits Form. **All expected out-of-pocket expenses, such as co-pays, are due at the time of service.** We may provide your information to your insurance carrier to help them determine payment of services. If your insurance company has not made payment within 60 days, then the balance is immediately due by you.

CONFIDENTIALITY

The confidentiality of your personal and health information is important to us. Legal and ethical standards require us to maintain confidentiality. Please review the attached HIPAA Notice of Privacy Practices form to understand how we will keep your health information confidential, and how we may use and disclose your health information as permitted or required by law. If your counselor receives clinical supervision, she or he will inform you of that specific process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

TRANSFER PLAN

In the event of the incapacitation, death, or termination of a therapist's practice at Life Balance Counseling, Inc. during the course of your treatment, your records will remain in our possession and a new therapist will be made available to you.

If you desire to transfer care outside of our practice, you may sign a release of records and we will release your initial intake and the most recent progress notes. It is our standard policy to release records directly to another provider.

AGREEMENT

I have read and understand the above statements on services, fees, policies, and procedures. My signature below indicates that I give my full consent to receive services at Life Balance Counseling, Inc.

Client (age 18 and over) _____ Date: _____

Client (age 12-17) _____ Date: _____

Client's guardian (for minors) _____ Date: _____

AGREEMENT RELATED TO LITIGATION

I acknowledge that _____ is a client of Life Balance Counseling.
(print name)

As the client or legal guardian of the client, I understand that the therapists' primary role is to treat his/her clients through effective therapy and counseling sessions. I understand that it is not the role of the therapist to become involved in court proceedings, custody disputes, visitation disputes, or any other legal dispute that may involve the client, and that the therapist cannot continue to treat the client as effectively if the therapist were to become involved in such legal proceedings.

By signing this document, I, as the client or legal guardian of the client, waive my right to involve my therapist in any court or legal preceding that may involve my child or me. I agree that I will not call on my therapist to forcibly testify in court on my behalf, unless my therapist believes, in exercising his/her professional judgment, that testifying to a court or an administrative law judge would be in the best interest of me or my child and our existing treatment relationship.

In the event that my treating therapist is requested, required by law, or subpoenaed to testify in a legal proceeding or deposition, I understand and acknowledge that:

1. I am responsible for the fees associated with the time spent by my therapist in preparing for and responding to written reports, legal documents and requests, and legal proceedings. This fee must be paid in advance before any such preparation and drafting of written reports is completed by my therapist. The fee will be $500 plus any reasonable attorney's fees incurred by the therapist.

2. I am responsible for the fees for my therapist to provide testimony at a deposition or in court. These fees must be paid at least one week prior to the date the therapist will be testifying. The fee is $750 for a three-hour block of time, plus any reasonable attorney's fees incurred by the therapist any time over 3 hours is at the rate of $300 per hour, plus any reasonable attorney's fees incurred by the therapist.

3. If the testimony is cancelled or rescheduled with less than two business days' notice, I am responsible for the fee owed to Life Balance Counseling for the payment of time lost for cancelled or unscheduled appointments. An additional fee for the same amount must be paid one week prior to the rescheduled date and time of the testimony.

4. I and my attorney will make a concerted effort to try to schedule my therapist's testimony at a time that is convenient to the therapist, as indicated by my therapist prior to the testimony being scheduled.

Client (age 18 and over) _____ Date: _____

Client (age 12-17) _____ Date: _____

Client's guardian (for minors) _____ 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 IT CAREFULLY.

Life Balance Counseling respects client confidentiality and only uses and discloses protected health information (PHI) about you in accordance with federal and state laws and ethics of the counseling profession. This notice describes policies related to the uses and disclosures of your health information.

USES AND DISCLOSURES OF YOUR PHI THAT DO NOT REQUIRE YOUR PRIOR AUTHORIZATION
In order to effectively provide you care, there are times when Life Balance Counseling will need to use and disclose your PHI for certain purposes without your authorization. Typically, we use and disclose your PHI in the following ways:

Treatment: Life Balance Counseling may use or disclose your PHI to provide, manage or coordinate your treatment, care or related services, which could include consultants and potential referral sources. For example, as part of your treatment with Life Balance Counseling, we may ask your other doctors for your overall health condition so that we can provide the most comprehensive treatment to you.

Payment: Life Balance Counseling may use and disclose your PHI to obtain payment for services provided. This may include contacting your insurance company or a third party to verify coverage and/or benefits, to process your claims, and to collect payment. For example, Life Balance Counseling may disclose the minimum amount of your PHI to a collection agency to obtain payment for services provided which have not been paid. With all uses and disclosures related to payment, we will use and disclose only the minimum necessary amount to achieve the intended purpose.

Healthcare operations: Life Balance Counseling may use and disclose your PHI as necessary to support our business activities including, but not limited to, quality assessment activities, employee review and training activities, licensing and other legal activities, and conducting or arranging for your treatment. For example, we may disclose your PHI to an attorney if a legal matter related to Life Balance Counseling arises. With all uses and disclosures related to health care operations, we will use and disclose only the minimum necessary amount to achieve the intended purpose.

WE MAY ALSO USE AND DISCLOSE YOUR PHI WITHOUT YOUR AUTHORIZATION, FOR THE FOLLOWING PURPOSES:

Victims of Abuse or Neglect: We may use and disclose PHI about you if we reasonably believe you are a victim of abuse or neglect. We will only disclose this type of information to the extent required by law, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.

To Avert a Serious Threat to Health or Safety: We may use and disclose your PHI when necessary to prevent a serious threat or death to your health and safety or the health and safety of the public or another person.

To Communicate with Individuals Involved in Your Care or Payment for Your Care: We may disclose your PHI to a family member, close personal friend, or any other person you identify as being directly related with the involvement in your care or payment related to your care. Additionally, we may disclose PHI to your "personal representative." If a person has the authority by law to make health care decisions for you, we will generally regard that person as your "personal representative" and treat him or her the same way we would treat you with respect to your PHI.

Worker's Compensation: To the extent necessary to comply with law, we may disclose your PHI for worker's compensation or other similar programs established by law.

Public Health: We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability, including the FDA. In certain circumstances, we may also report work-related illnesses and injuries to employers for workplace safety purposes.

Health Oversight Activities: We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs and compliance with civil rights laws.

Law Enforcement: We may disclose your PHI for law enforcement purposes as required or permitted by law, or if a crime is committed on the premises of Life Balance Counseling.

Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery

request, or other lawful process instituted by someone else involved in the dispute with certain satisfactory assurances.

Research: We may use your PHI to conduct research and we may disclose your PHI to researchers as authorized by law. For example, we may use or disclose your PHI as part of a research study when the research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Fundraising: As permitted by applicable law, we may contact you to provide you with information about our fundraising programs. You have the right to "opt out" of receiving these communications if you do not want us to contact you further for fundraising efforts.

WE MAY USE AND DISCLOSE YOUR PHI ONLY WITH YOUR PRIOR AUTHORIZATION, FOR THE FOLLOWING PURPOSES:

Specific Uses or Disclosures Requiring Authorization: We will obtain your prior written authorization for the use or disclosure of your psychotherapy notes, use or disclosure of your PHI for marketing purposes, and for the sale of your PHI, except in limited circumstances where applicable law allows such uses or disclosure without your authorization.

Other Uses and Disclosures: We will obtain your written authorization before using or disclosing your PHI for purposes other than those described in this Notice or otherwise permitted by law. You may revoke your authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI.

YOUR HEALTH INFORMATION RIGHTS
You have a right to the following:

Obtain a copy of this Notice upon request: You may request a copy of this Notice at any time. You may obtain a copy at the site where you obtain health care services from us or by contacting the Privacy Officer.

Request a restriction on certain uses and disclosures of PHI. You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Officer. We are not required to agree to the restrictions, except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations and the PHI pertains solely to a health care item or service for which you, or a person on your behalf, has paid in full out-of-pocket.

Inspect and obtain a copy of PHI: With a few exceptions, you have the right to access and obtain a copy of the PHI that we maintain about you. If we maintain an electronic health record containing your PHI, you have the right to request to obtain the PHI in an electronic format. To inspect or obtain a copy of your PHI, you must send a written request to the Privacy Officer. You may ask us to send a copy of your PHI to other individuals or entities that you designate. We may deny your request to inspect and copy in certain limited circumstances, for which we will explain the denial. If you are denied access to your PHI, you may request that the denial be reviewed by another person within Life Balance Counseling.

Request an amendment of PHI: If you feel that the PHI we maintain about you is incomplete or inaccurate, you may request that we amend it. To request an amendment, you must send a written request to the Privacy Officer. You must include a reason that supports your request. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it, and you have the right to send us a statement of disagreement of why you disagree with our denial. Your statement of disagreement will be kept and filed with the rest of your PHI that we maintain about you.

Receive an accounting of disclosures of PHI: With the exception of certain disclosures, you have a right to receive a list of the disclosures we have made of your PHI, in the six years prior to the date of your request, to entities or individuals other than you. To request an accounting, you must submit a request in writing to the Privacy Officer.

Request communications of PHI by alternative means or at alternative locations. You have the right to request that we communicate with you about your PHI in a certain way or at a certain location. For example, you may request that we contact you at a different residence or post office box. We will accommodate all reasonable requests. Please note if you choose to receive communications from us via e-mail or other electronic means, those may not be a secure means of communication and your PHI that may be contained in our e-mails to you will not be encrypted. This means that there is risk that your PHI in the e-mails may be intercepted and read by, or disclosed to, unauthorized third parties. To request confidential communication of your PHI, you must submit a request in writing to the Privacy Officer.

Notification of a Breach: You have a right to be notified following a breach of your unsecured PHI, and we will notify you in accordance with applicable law.

Contact: You may submit written requests to the Privacy Officer at 1305 Remington Rd, Suites U, Schaumburg, IL 60173 or by telephone at 888.234.7628. If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer of Life Balance Counseling or with the Secretary of Health and Human Services at the Office for Civil Rights at 200 Independence Avenue SW, Washington, DC 20201. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt:

I, _____, acknowledge that I received LBC's currently effective HIPAA Notice of Privacy Practices, and that LBC must provide me with an electronic copy of the HIPAA Notice of Privacy Practices should I request it.

_____
Signature of patient or personal representative

_____
Date

CLIENT WAIVER COVID-19

To begin or resume in-person session, you agree to take necessary precautions to protect yourself, me, my staff, and our families from exposure to COVID-19. If you do not adhere to these precautionary requirements, I reserve the right to terminate in-person sessions. Telehealth may remain as an alternative to any in-person sessions. Initial each provision to indicate that you understand and agree to each required safeguard:

- You agree to wash your hands with soap or an alcohol-based sanitizer before entering and leaving the building.
- You agree to take your temperature before each in-person session. If your temperature is higher than 100 degrees Fahrenheit or if you have any other symptoms, you agree to immediately notify me or my office and agree to cancel the in-person appointment. You will not be charged a cancellation fee. Telehealth will remain as an alternative option for therapy.
- You agree to adhere to any safe distance measuring policy in the building, waiting room, and in our office.
- You agree to wear a mask in the hallway, and if you are waiting in the waiting room, you will wear a mask the entire time.
- You agree to maintain a safe distance of six feet from myself and from all staff.
- You agree to avoid all physical contact e.g. handshakes.
- You agree to not bring in any unannounced visitor before the session.
- You agree to take precautionary steps to minimize your exposure to COVID-19 before and between appointments.
- You agree to notify me if you or a member of your household was reasonably exposed to COVID-19.
- You agree to notify me if you or a member of your household works in an environment that is frequently exposed to COVID-19.
- You agree to notify me if you or a member of your household has tested positive for COVID-19.

- I reserve the right to amend, add, or abrogate any of the foregoing precautions according to any published federal, state, or local health guidelines. I will notify you of any changes to the agreement.
- In certain circumstance, I may be required to notify federal, state, or local health authorities that you have been in the office. This may occur if you have tested positive for COVID-19. If I am required to report this, I will only report the minimum information necessary to perform their health duties.

Disclaimer: The information at the time of publishing this article is believed to be current and accurate. However, our understanding of the COVID-19 virus frequently changes. Therapist must follow federal, state, and local officials for new and updated guidelines. The information provided in the article is not to be relied upon as legal advice. A signed informed consent form does not waive all liability for therapists. You are encouraged to contact an attorney licensed in your respective state to obtain guidance to your specific situation.

AGREEMENT

I have read and understand the above statements on COVID-19 policies and procedures. My signature below indicates that I agree to the terms stated by Life Balance Counseling, Inc.

Client's name (printed) _____ Date: _____

Client's signature (18 years & over) _____ Date: _____

Client's signature (ages 12-17 years old) _____ Date: _____

Client's guardian (for minors) _____ Date: _____