INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____
(Last) (First) (Middle Initial)

Name of parent/guardian (If under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female

Marital Status:

□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

_____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell Phone: ( ) May we leave a message? □ Yes □ No

E-Mail: _____ May we email you? □ Yes □ No
*Please note: E-mail correspondence is not considered to be confidential medium of communication

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No □ Yes, previous therapist/practitioner: _____

I allow you to bill my insurance company based on the above information.

Patient's Signature_____ Date:_____

Are you currently taking any prescription medication?

□ Yes
□ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?

□ Yes
□ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe:_____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage in recreational drug use?

□ Daily □Weekly □Monthly □Infrequently □Never

10. Are you currently in a romantic relationship? □ Yes
□ No

If yes, for how long?_____

On a scale of 1-10 (1 the worst, 10 the best), how would you rate your relationship?
_____

11. What significant life changes or stressful events have you experienced recently?

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY

In this section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle		List Family Member
Alcohol/Substance Abuse	Yes	No	
Anxiety	Yes	No	
Depression	Yes	No	
Domestic Violence Eating	Yes	No	
Disorder	Yes	No	
Obesity	Yes	No	
Obsessive Compulsive Disorder	Yes	No	
Schizophrenia	Yes	No	
Suicide Attempts/Suicide	Yes	No	

ADDITIONAL INFORMATION

1. Are you currently employed?

□ Yes
□ No

If yes, what is your current employment situation?

_____

Do you enjoy work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious?

□ Yes
□ No

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

SOCIAL HISTORY WORKSHEET

Personal History

Place of Birth:_____

Place patient lived during development years: _____

Last grade completed in school: _____

Specialized training and skills: _____

_____

Military Service? _____

Previous employment/occupations: _____

_____

Current Employer: _____ How Long? _____

Marital Status: Married Divorced Separated Widowed Single

Spouse's Name: _____ Length of Marriage: _____

List any previous marriages and length of marriages:

_____

_____

Names and Ages of all Children:

_____

_____

Family History

Parents Living? □ Yes □ No

Parents' Names, Ages, and Location:_____

_____

Parents' Occupations:

_____

Siblings? □ Yes □ No

Siblings' Names, Ages, and Location: _____

_____

With whom in the family do you feel the closest with?

_____

Most distant?

_____

Other information regarding family history: _____

_____

Socialization

Clubs, Groups, or Activities you participate in: _____

_____

Do you attend Church? □ Yes □No

Other interests:_____

If you drink alcohol, what do you drink and how much?

_____

Do you or have you used drugs? □ Yes □ No

If yes, what and how often?_____

_____

Living Arrangements

Please Circle: House Apartment Rent Other

Other information: _____

Is the living space adequate? □ Yes □ No If no, specify: _____

Previous Psychiatric History

Are you currently seeing a Psychiatrist? □ Yes □ No

If yes, who and for how long?_____

Current Medications_____

_____

Past Medications_____

_____

Other helpful Information _____

_____

_____

A New Direction Counseling Center
William C. Edleman LCSW, MSW
461 N. Mulford Rd, Ste 8
Rockford, IL 61107

Acknowledgment of Receipt of Notice of Privacy Practices

Patient/Client
Name:_____

Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of the Notice of Privacy Practices of William C. Edleman, LCSW, MSW. I understand that if I have any questions regarding the Notice of Privacy Practices, I can contact William C. Edleman, LCSW, MSW.

_____
Signature of Patient/Client Date

_____
Signature of Parent/Guardian/Personal Representative Date

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

_____Patient/Client Refuses to Acknowledge Receipt. Date_____

_____
Signature of William C. Edleman, LCSW Date

CANCELLATION POLICY

As a general courtesy, **this office will attempt to call you 2 days before your scheduled appointment.** If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee will be charged for missed appointments or cancellations with less than a 48-hour notice unless it is due to illness or an emergency with proper documentation. **The sooner you contact our office would be much appreciated. Your insurance does NOT cover this.** A bill will be mailed directly to all clients who do not show up for their appointment or cancel after the 48-hour period.

Thank you for your consideration regarding this important matter.

_____

Client Signature (Client's Parent/Guardian if under 18)

_____

Today's Date

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's guardian. **We ask that you use NO recording devices** are during the session and assure you that your session will not be recorded or taped. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to the legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Today's Date

William C. Edleman
461 N. Mulford Rd, Ste 8
Rockford, IL 61107
815-227-1522

PAYMENT POLICY

William Edleman has a strong commitment to quality psychotherapy. To assure such a commitment, his office must maintain a sound financial position. It is important that patients pay all accounts as quickly as possible.

DAY OF SERVICE: Patient must pay their accounts in full at the time of service, unless they have made advance financial arrangements. Patients may pay their accounts by cash, check, credit card, or money order.

The office will bill insurers with proper information provided at the time of registration. The patient (not the insurance company) is responsible for payment of his/her account. Patients with commercial insurance are required to pay 10% of their total balance each month until we receive your insurance payment. When your invoice balance is over 90 days old, payment in full is due whether or not your insurance carrier has processed your claim.

MEDICARE: When Medicare assignment is accepted, your provider has agreed to accept as payment the amount Medicare determines to be allowable. You are responsible for the coinsurance (50% of the Medicare allowable for outpatient, 20% of the Medicare allowable for inpatient), any remaining portion of your deductible, and all non-covered charges. We will automatically submit a claim to your supplemental insurance (when information is on file). Your balance is due within 30 days of receiving our statement balance due, after Medicare has paid their portion, unless you have made other arrangements with the business office. You will receive a statement of balance due each month until paid in full.

The office will bill participating Health Plans with proper information provided at the time of registration. The patient is responsible for the coinsurance, deductible, and all non-covered charges. If the invoice reaches 90 days old, payment in full is due by the patient whether or not the PPO carrier has processed the claim.

PHONE CALLS: As of February 1, 2019 phone calls will be charged as $25.00 for every 5 minutes of service provided. **Please remember that insurance DOES NOT cover phone calls**. Payment is due at the time of the next scheduled appointment or in 30 days, whichever comes first.

MISSED APPOINTMENTS: Missed appointments will be charged at $125.00. 48 hour notice is required unless there is a medical emergency.

COLLECTION: Patients are responsible for any charges related to the cost of collection of their account, including, but not limited to collection agency commission and reasonable attorney's fees and costs of suit which are incurred by this office in enforcing payment policies. ALL FUTURE SERVICES ARE ON A CASH BASIS.

I have read and understand the above policy.

_____ _____

Signature of Insurer Date

_____ _____

Signature of Patient Date

A NEW DIRECTION COUNSELING CENTER
William C. Edleman, LCSW, MSW
815-227-1522

NOTIFICATION TO PATIENT OF DESIRABILITY OF CONFERRING WITH PRIMARY CARE PHYSICIAN

Pursuant to Illinois law, you are hereby informed it is desirable that you confer with your primary care physician, if you have one. If you have a primary care physician, I am required to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

Please indicate your wishes:

☐ My primary physician is _____

Address _____

☐ I agree to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing the attached Authorization of Release Information permitting you to communicate with my said physician.

☐ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to so notify him/her.

☐ I do not have a primary care physician and do not wish to see or confer with one. I, therefore, WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

Date_____ Patient Signature_____

Parent or Guardian of minor patient or ward_____

NOTIFICATION TO PRIMARY CARE PHYSICIAN OF PATIENT RECIEVING MENTAL HEALTH SERVICE

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their patients' primary care physicians that a patient is seeking or receiving mental health services, you are hereby notified that _____ is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your record. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996 as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point, your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. *Special Instructions for Completing this Authorization for the Use and Disclosure of Psychotherapy Notes.* HIPAA provides special protections to certain medial records known as "Psychotherapy Notes". All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session, and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

7. In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is subject of the "Psychotherapy Notes" must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.