Annemarie Husser LCPC, LLC

455 Coventry Lane, Suite 105, Crystal Lake, IL 60014

Client Intake and Consent to Treatment

Contact Information:

First Name: _____M.I._____Last Name:_____

Date of Birth:_____

Street Address: _____Apt./Unit# _____
City:_____State:_____ Zip Code:_____

Home Phone: _____ Cell Phone: _____

Email:_____ Can I leave a message or text**?**_____

Person to Contact in Case of an Emergency:

Name: _____ Phone Number: _____

Family Information:

Marital Status: Single Married Divorced Widowed Living with Partner

Name/Age of Spouse/Partner:

Names/Ages of Children:

Names/Ages of Siblings:

Employment/Education Information:
High School:
College (if applicable):
Current Employer: Position:

Medical/Psychological Information:
Presenting Problem: (Why are you coming to counseling?)

Past Counseling/Psychotherapy: (For this or other condition?)

Medical History: (Please describe current medical condition and any past history of disease, surgery, etc.)

Current Medications:

Primary Care Physician:
Name: City: Phone Number:

May I notify your Primary Care Physician that you are receiving mental health services?
Yes **No**
Psychiatrist:
Name: City: Phone Number:

Insurance Information:
Policy Holder (Member) Name:
Relationship to client:
Policy Holder D.O.B:
Name of Insurance Company:
Phone Number:
Member ID: Group /Plan#

How did you hear of my services?

Consent to Treatment:

I hereby consent to treatment with Annemarie Husser LCPC. I understand that I am responsible for full payment of the fee regardless of my health insurance coverage or benefits. I understand that full payment or payment of the applicable co-pay is expected at each session. I understand that if I need to cancel an appointment, **I must provide at least 24 hour notice,** and that if an appointment is cancelled or missed without such notice, I will be responsible for a **late cancellation fee of $50.00 and a no show fee of $75.00**. I understand that if my account is in arrears, a collection agency or attorney may be retained to collect any past due amount. As in all counseling practices, there is no guarantee of a positive outcome.

Counseling is confidential. Your therapist will use and protect your information in compliance with applicable state and federal law. Information obtained during counseling sessions will not be disclosed to anyone without your knowledge and written consent, with the following exceptions: if your therapist believes that you present an imminent, serious risk of injury or death to yourself or another; if your therapist has reasonable cause to believe a child's well-being or safety is compromised; if your therapist has reason to believe that an individual who is protected under the *Illinois Elder Abuse and Neglect Act* has been abused, neglected, or financially exploited; or if your therapist receives a valid court order signed by a judge.

I have discussed this form with my therapist, and I understand and agree to the terms outlined above.

***S*ignature of Client:** _____ Date: _____
(Children 12-18 years must sign)
Signature of Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____