Phoenix Rising Solutions, LLC
to educate, empower, & enlighten

Intake Information

Thank you for choosing Phoenix Rising Solutions, LLC for your counseling needs. We are happy to guide you on your path to health and wellness. Through our integrative approaches, we can help you achieve your goals, strengthen your resolve and coping skills, and get into better touch with the interplay of your thoughts, feelings, and behaviors. Before you begin therapy, we would like you to be aware of the benefits and risks and our procedural business practices. You are asked to fill out your identifying information below, provide us your authorized payment information, and sign this document (p 4.) that you have read and agreed to all policies.

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

Name of parent/guardian (if under 18 years old)

_____
(Last) (First) (Middle Initial)

Birth Date: ____/_____/____ Age: _____ Gender: ☐ Male ☐ Female ☐ _____

Marital Status:

☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partnership

Please list any children/ages: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

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

Cell/Other Phone: ( ) _____ May we leave a message? ☐ Yes ☐ No

Other Type: May we text you appointment reminders or for other purposes? ☐ Yes ☐ No

Email*: _____ May we email you? ☐ Yes ☐ No

**Please note: Email correspondence is not considered to be a confidential medium of communication. Phoenix Rising Solutions, LLC may send information on workshops, groups, and relevant health-related information. By providing your email address, you are consenting to information being sent to you.*

Referred by: _____

Benefits and Risks of the Therapeutic Process of Counseling:
Before beginning therapy at Phoenix Rising Solutions, LLC, you should be aware of the possible benefits and risks of counseling services. The majority of people generally benefit from the therapeutic process, which is very useful and typically results in a better understanding of yourself (e.g., thoughts, feelings, and actions), improved mood, increased self-esteem, and greater ability to make decisions that reflect your values and goals. However, some risks do exist in the course of therapy. For example, people can experience unwanted feelings, thoughts, bodily sensations, and images, mainly because we are bringing to surface the very things that need to be worked on and are holding you back from living the life you desire. Some feelings may include sadness, frustration, guilt/shame, overwhelm, loneliness, jealousy, fear, etc. When emotions arise in counseling, the experience can be unexpected and distressing. Some may want to avoid such occurrences by cancelling appointments or not engaging in support activities. We are here to help you safely navigate through any feelings that present themselves with care and comfort. Resourcing you is our number one goal so that we can slowly peel back the protective armoring you have created in defense and face problems together.

The more open and honest you are with your counselor, the better your counselor can help you work these uncomfortable experiences. Issues are better confronted in a therapeutic relationship (inter-relational) that will later transfer into self-healing/-agency (intra-relational) skills. Everyone experiences discomfort or pain in life, and therapy helps you to find coping skills that work for you to accept, confront, and move through it. We strive to transform these undesired feelings into something more manageable, instead of being wrapped up in them, and to navigate more easily through your life to reach your goals. These somewhat challenging experiences are likely to provide new perspectives about your situation and assist you with your present and future goals on how you would like your life to unfold and be.

Counseling sessions are approximately 50 minutes based on the service provided. Kindly, we advise you that we collect payment, schedule your next appointment, and document session notes during the remaining minutes of the hour. Consistent attendance and participation in therapeutic activities in session and support exercises outside of session will produce the maximum possible benefits. While you may expect certain benefits from this treatment, such benefits or desired outcomes cannot be guaranteed. Phoenix Rising Solutions, LLC will do their best to help you reach your goals using an approach tailored to your specific concerns. However, you/we are free to discontinue treatment at any time in accordance with policies of the office.

Hours & Availability:
Phoenix Rising Solutions, LLC is answered directly by a counselor, other staff, or switched over to a voicemail system 24 hours a day, 7 days a week. Therapists are expected to return calls promptly, usually within 24-48 hours except weekends, but at times are unable to return calls as soon as you may need. In the event your therapist is unavailable and you are in an emergency situation, call 911, call your primary care physician or psychiatrist, go to the nearest emergency room, or contact the Community Crisis Center at (847) 697-9740 in Elgin or the Crisis Line of the Fox Valley at (630) 966-9393.

Insurance, Payment, and Fees:
Payment for each session is expected at the time services are rendered. If you have insurance or employee assistance program (EAP) benefits, you are responsible for whatever portions your insurance or EAP does not cover. This may include deductible, co-payment/co-insurance, and non-covered, ineligible, or unauthorized services. We accept cash (exact change), checks, debit cards, and credit cards. If payment is not made at the time of service, we will bill your authorized payment, which is required to begin services. If your bill is not paid within 60 calendar days of the initial date of service, we have the right to turn your account over to collections or small claims court. Any fees, including attorney's fees, associated with recovering an unpaid bill will be the responsibility of the client. As a courtesy to our clients, we attempt to contact your insurance company or EAP to obtain benefit information for your care. Benefit information given to clients by our office is not a guarantee of payment by your insurer.

Insurance Payment, and Fee: continued

It is recommended that clients directly inquire with the insurance company or EAP about their health benefits.

When we bill for services, you should be aware that most insurance agreements require your therapist to provide a clinical diagnosis. This information will then become part of the insurance company files. All insurance companies claim to keep such information confidential. It is important to remember that you always have the right to pay for services directly and avoid the reporting and complexities associated with insurance coverage.

In cases where the client is a minor child, the parent/guardian is responsible for the bill.

Fee Schedule:

- Intake sessions are $175
- Ongoing sessions are $150-$175
- Phone Conversations (outside of sessions) $60 per 15-minute intervals
- Letter Writing $60 per 30-minute intervals
- Late cancellations/no show fee is $75 per incident
- Returned check fee is $50 for insufficient funds and other charges that we incur as a result
- Collection agency/small claims court/attorney's fees for accounts not paid within 60 days of initial date of service, if necessary

Fees are subject to change. You will be notified of any changes to the fee schedule.

Cancellation Policy:
If you need to cancel or change an appointment, **notify the office at least 36 hours prior to the therapy appointment or group session** in order to avoid being charged the cancellation fee outlined in the fee schedule. Payment of cancellation fee will be made through authorized payment. If there is an opportunity for you to reschedule to another appointment time, payment may be made directly at your next appointment or through authorized payment. If you do not return for future services, a bill for fees incurred will be charged to your authorized payment on your behalf or be mailed directly to you if authorized payment is insufficient.

Communication & Social Media Policy:
Phoenix Rising Solutions, LLC does not use e-mail, social media platforms (FB, LinkedIn, Snapchat, IG, etc.) for personal interactions and/or addressing clinical issues with current, past, or potential clients for any reason, including scheduling, changing, or canceling appointments. We prefer that you text us for schedule changes and/or call us at our HIPPA-compliant phone number to discuss any concerns; we will most likely refer you to scheduling an appointment or seeking other emergency care if we are unable to schedule you right away and you require such assistance. We will text appointment reminders with our HIPPA-compliant practice management software. You are ultimately responsible to remember and keep your appointment day and time.

Continuity & Consistency of Care
While in therapy, it is important to keep a regular schedule of appointments to consistently work on your goals. When appointments are frequently cancelled and/or rescheduled, these treatment interfering behaviors hinder progress in therapy and the therapeutic relationship. If a client is not seen for more than 30 calendar days, unless prior arrangements have been made, your file is administratively closed. Your therapist is no longer **legally** considered your mental health care provider. You can reopen your file as a client at any time and continue therapy. We are here to help and want you to be well with consistent and continuous care.

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Consent to Treatment Form

I consent to take part in treatment at Phoenix Rising Solutions, LLC. I have received and read the **Intake Information** form explaining the risks and benefits of therapy; hours and availability; insurance, payment, necessary authorized payment on file, and fees; and other policies, and agree to its terms.

I have received and read the **HIPPA Notice of Privacy Practices** including **Client Rights**. I will ask for explanation and clarification of any part of the Intake Information, HIPPA Notice of Privacy Practices, or Client Rights that I do not understand.

I understand that **I am responsible for my bill**. While Phoenix Rising Solutions, LLC will assist me in pursuing insurance or employee assistance program (EAP) reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency or small claims court. I understand that Phoenix Rising Solutions, LLC may elect to end treatment or treatment may be interrupted if timely payment for services is not made. A debit or credit card is required on file for services to commence.

I understand that regular and consistent attendance as well as completing support activities will yield the maximum possible benefits. Furthermore, I or we are free to discontinue treatment at any time in accordance with the policies of the office.

I understand that I will be charged $75 for failing to show or for failing to give at least **36 hours' notice when cancelling an appointment**.

If I am electing to use my insurance or EAP benefits, I authorize release of the necessary information to my insurance company or EAP so that Phoenix Rising Solutions, LLC may pursue payment for the services provided to me. I authorize insurance or EAP payments to be sent directly to Phoenix Rising Solutions, LLC.

Sign below if you are in agreement with the entirety of this and other related documents described herein.

Client Signature	Date
Parent/Guardian Signature	Date

Note: Parent signs for clients under the age of 12 years old. If client is between 12 and 18 years old, both client and parent/guardian signatures are required.

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Insurance and Payment Information Form

Fill out the following information and answer the questions below about your insurance. Bring this form, driver's license, and insurance card to your first session.

Financially Responsible Party:
☐ Client
☐ Insured (other than client)
☐ Other

Client's relationship to policy holder:
☐ Self
☐ Spouse
☐ Child
☐ Other

Insured's/Responsible Party's Name: _____

Insured's Date of Birth: _____ Insured's SSN: _____

Insured's Address: _____

☐ Home / ☐Cell Phone: _____ Alternate Phone: _____

Insured's Employer: _____

Insured's Work Address: _____

Insured's Work Phone: _____

Insurance Company: _____ (check one) ☐ PPO ☐ HMO ☐ POS

Member ID#: _____ Group/Plan #: _____

Insurance Company Phone: _____ Insurance Effective Date _____

AUTHORIZATION TO SECURE PAYMENT/CREDIT CARD INFORMATION

I authorize Phoenix Rising Solutions, LLC to process payment on my credit card for any fees associated with a visit including any balance due that has not been paid 30 days after the date of service was received, when I miss a scheduled appointment, or fail to provide 36 hours' notice prior to a scheduled appointment.

_____ _____
Cardholder's Name Client's Name

_____ _____ _____
Credit Card Account Number Expiration Date CVV Code (3-digit code)

_____ _____
Signature of Cardholder Today's Date

HIPPA Notice of Privacy Practices/Limits to Confidentiality

THIS NOTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: July 1, 2012

The rules for confidentiality of mental health records are detailed in the Illinois Mental Health and Developmental Disabilities Confidentiality Act and in the privacy rules of the Health Insurance Portability and Accountability Act. 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 legal guardian. Phoenix Rising Solutions, LLC, its therapists, and staff respect your privacy and only release medical information in accordance with federal and state laws. Any client information in paper form is locked in a filing cabinet and any electronic information is password protected to ensure your privacy. This notice describes our policies related to the use and disclosure of your records for your care.

Use and Disclosure of Protected Health Information For the Purpose of Providing Services:

Treatment: We may use or disclose medical information about you to provide, coordinate, or manage your care or any related services, including sharing information with others that I may be consulting with or referring to.

Payment: Information will be used in order to obtain payment for treatment provided. This will include contacting your insurance company to verify insurance and coverage and for billing purposes, such as processing claims and collecting fees.

Healthcare Operations: We may use information about you to coordinate business activities. This may include billing activities, scheduling appointments, and reviewing your care.

Insurance Providers: Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Access to Your Mental Health Record:

1) an adult recipient of services, defined as 18 years of age or older

2) the parent/guardian of a child who is under 12 years of age

3) the recipient if s/he is 12 years of age or older

4) the parent/guardian of a recipient who is at least 12 but under 18, if the recipient does not object or if the therapist does not find that there is a compelling reason for denying access. Nothing in this statement is intended to prevent a parent/guardian of a child who is at least 12 but under 18 from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed

5) a legal guardian of a recipient who is 18 or over

6) an attorney, guardian ad litem, or power of attorney or other person who is legally authorized to access the record

HIPPA Notice of Privacy Practices/Limits to Confidentiality-continued

Information Disclosed Without Your Consent

Under Illinois and federal law, information may be disclosed without your consent in the following circumstances:

Mandated Reporting/As Required By Law:

- Danger to Self or Others: When a client discloses intentions or a plan to harm another person, when there is prenatal exposure to controlled substances, or when the client discloses or implies a plan for suicide, the mental health professional is required to report this information to legal authorities. We will make reasonable attempts to notify the family of the client when the client is suicidal.

- 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.

Emergency Medical Care: Sufficient information may be shared to address the immediate emergency you are facing if you are not in a condition to waive or assert your rights.

Criminal Activities: If a crime is committed on the premises or against anyone on the premises, we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

Follow-Up Appointment/Care: We may be contacting you to remind you of future appointments, for information about treatment alternatives, or for other health related benefits and services that may be of interest to you.

Governmental Requirements: We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. We are also required to share information if requested with the Department of Health and Human Services to determine compliance with federal laws related to health care.

CLIENT RIGHTS STATEMENT

Phoenix Rising Solutions, LLC strives to bring you the best care for you, your family, or business. We offer services that are compassionate, respectful and considerate.

The qualifications of the person that provides services to you are always available for your review when requested and some basic information is also available on the Phoenix Rising Solutions, LLC website.

Our care is consistent with all applicable state laws and the following professional ethical standards:

a. For clinical social workers, the National Association of Social Workers

b. For clinical counselors, the American Mental Health Counselor Association

c. For marriage and family therapists, the American Association for Marriage and Family Therapists

d. For psychologists, the American Psychological Association

We encourage your full and meaningful participation in the planning, implementation, and termination or referral of your treatment.

Our therapists will inform you of the risks and benefits of: treatment, alternative treatments, and refusing treatment. In addition, we will inform you of our practice policies regarding office hours, fees, missed appointments, billing procedures, and other relevant matters except as otherwise provided by law.

Below, you have the following rights under state and federal laws:

Alternative Communication. You may request that we communicate with you about your health information to another address or alternative means. We will honor the request as long as it is reasonable, and we are assured it is correct. We have the right to verify that the payment information you are providing is correct.

Release of Records**.** You may consent in writing to release your record to others, for any purpose you chose. This includes your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time in writing but only to the extent no action has been taken in reliance on your prior authorization.

Inspection and Copy of Record. You are entitled to inspect or copy the medical record we have generated for you. We may deny this request, if we feel this is in your best interest. We charge a reasonable fee for copying and mailing records.

Amending Record. If you believe that something in your record is incorrect or incomplete you may request that we amend it. Your request must be in writing. If your request is denied, you have the right to file a statement that you disagree with the denial. We will file a response to your statement, which will be added to your record.

Accounting of Disclosures. You may request an accounting of any disclosures made related to your medical information, except for information used for treatment, payment, or health care operations purposes; or that was shared with your family; information for which you provided consent to release; or for national security or law enforcement.

Restriction on Record. You may ask your therapist not to disclose part of the medical information. This request must be in writing. We are not required to agree with your request if we believe it is in your best interest to permit use and disclosure of the information.

Questions and Complaints. If you have any questions or complaints about this policy, please contact your therapist first. If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of Health and Human Services.

Changes in Policy. We reserve the right to change this policy and its terms at any time, provided such changes are permitted by applicable law. You will be notified of any changes to this policy.