

Illinois Valley Counseling Services, LLC

PATIENT INFORMATION

It is our policy that all information be complete, including the social security numbers. If you refuse to give social security numbers, then we reserve the right to refuse you as a patient. This information is kept confidential. It is not used for anything other than our own personal records and means of identifying you.

Patient Name (Last, First, M.)

DOB:

AGE:

Address (Street, City, State, Zip)

SSN:

Marital Status: Single Married Separated
Divorced Widowed Civil Union

Phone Number:

Employer:

Address:

Phone Number:

Spouse's Name:

DOB:

SSN:

Spouse's Employer:

Address:

Phone Number:

*****JOINT/SPLIT CUSTODY AND DIVORCE SITUATIONS*****

In cases of divorce, it is *our policy* that any amount left owed after insurance has been paid will be the responsibility of the *parent who brings the child for their appointments*. This is between you and your ex-spouse. We do not bill to anyone other than the parent who initiated the appointment and brings them for their appointments. No exceptions.

Is This Patient a Minor? YES NO If yes, please fill out the following parent information.

Mother's Name (Last, First MI.):

DOB:

Address (If Different):

Phone Number:

Place of Employment and Address:

SSN:

Work Phone Number:

Is this person a patient?

YES

NO

Father's Name (Last, First MI.):

DOB:

Address (If Different):

Phone Number:

Place of Employment and Address:

SSN:

Work Phone Number:

Is this person a patient?

YES

NO

INSURANCE INFORMATION

Primary Insurance Name:

Policy ID:

Group ID:

Subscriber's Name:

DOB:

SSN:

Insurance Phone Number:

Patient's Relationship to Subscriber: Self Spouse Child Other (Explain):

Secondary Insurance Name:

Policy ID:

Group ID:

Subscriber's Name:

DOB:

SSN:

Insurance Phone Number:

Patient's Relationship to Subscriber: Self Spouse Child Other (Explain):

IN CASE OF EMERGENCY: Name:

Relationship:

Phone Number:

The above mentioned is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I *am financially responsible for any and all balances*. I also authorize Illinois Valley Counseling Services, LLC to release any information required to process my claims to the insurance. I also understand that if my account becomes delinquent and is sent over to collections there will be a 25% fee accessed on the account balance. SIGNATURE: DATE:

Illinois Valley Counseling Services, LLC

747 East Etna Road, Ottawa, IL 61350

901 Main Street, Mendota, IL 61342

1802 N. Division St, Suite 403. Morris, IL 60450

FINANCIAL/INSURANCE POLICY:

As a courtesy, Illinois Valley Counseling Services, LLC will bill your insurance company, responsible party, or third party payer. Insurance Companies require that we collect all co-pays at each session. If your deductible has not been met, the full fee is due at each session until it has been met. If your insurance company denies payment or denies coverage for services rendered, payment in full is required for the balance due.

If you need to cancel or reschedule an appointment, please give 24 hours notice, otherwise a missed appointment/late cancel fee will be charged.

\$75 missed appt./late cancel fee

Checks which are declared non-sufficient funds or stop payment, will be charged a \$25.00 service fee. Accounts turned over to a collection agency for non-payment will have a 25% fee accessed on the account balance.

I authorize my insurance benefits to be paid directly to Illinois Valley Counseling Services, LLC. I understand that

I am financially responsible for any balance.

I also authorize Illinois Valley Counseling Services, LLC or insurance company to release any information required to process my claims. I have received a copy of the Illinois Valley Counseling Services, LLC fee schedule. I have read and accepted the Illinois Valley Counseling Services, LLC financial policy noted above.

Signature _____ Date _____
(Patient Signature 12 years and older)

Printer Name: _____

Signature _____ Date _____
(Parent/Legal Guardian-Guarantor Signature)

Printed Name: _____

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INFORMED CONSENT:

Thank you for choosing Illinois Valley Counseling Services, LLC. Today's appointment will take approximately 50-60 minutes. We realize that starting counseling is a major decision and you may have some questions. This document is intended to inform you of our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

All the providers at Illinois Valley Counseling Services, LLC are licensed and or credentialed in their respective fields. Our therapists practice standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for:

- a) Information shared with our staff psychiatrist;
- b) Information (diagnosis and dates of service) shared with your insurance company to process your claims
- c) Information you and/or your child or children report about physical or sexual abuse. Then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services;
- d) Where you sign a release of information to have specific information shared;
- e) If you provide information that informs me that you are in danger of harming yourself or others;
- f) Information necessary for case supervision or consultation;
- g) When required by law.

As of 2008, the new FOID Law requires reporting on any patient whose mental condition is such a nature that is manifested by violent, suicidal, threatening, or assaultive behavior or reported behavior, for which there is reasonable belief by a clinician that the condition poses a clear and present or imminent danger to the patient, any other person, or the community meaning the patient's condition poses a clear and present danger in accordance with subsection (f) of Section 8 of the Firearm Owners Identification Act.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those counseling and support to the client or the client's family.

Signature(s) _____ Date _____
(Patient Signature 12 years or older)

Signature(s) _____ Date _____
(Parent/Legal Guardian Signature)

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HIPPA NOTICE OR 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.

Effective Date: August 1, 2015

Illinois Valley Counseling Services, LLC has been and will always be totally committed to maintaining client's confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics or the counseling profession.

This notice describes our policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purpose of providing services:

Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

TREATMENT:

We may need to use or disclose health information about you to provide, manage, or coordinate your care or related services which could include consultants and potential referral sources.

PAYMENT:

Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

HEALTHCARE OPERATIONS:

We may need to use information about you to review our treatment procedures and business activity. Information may be used for certification, compliance, and licensing activities.

Other uses or disclosures of your health information which does not require your consent.

There are some instances where we may be required to use and disclose information without your consent.

For example, but not limited to:

- a). Information you and /or your child or children report about physical or sexual abuse; then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services.
- b). If you provide information that informs us that you are in danger of harming yourself or others
- c). Information to remind you of/or to reschedule appointments or treatment alternatives.
- d). Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law, such as a subpoena or court order.

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CLIENT RIGHTS

RIGHT TO REQUEST HOW WE CONTACT YOU:

It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders, etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

RIGHT TO RELEASE YOUR MEDICAL RECORDS:

You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization.

RIGHT TO CONFIDENTIALITY:

Every client has the right to confidentiality. Confidentiality at Illinois Valley Counseling Services, LLC is maintained in a manner consistent with the Federal Confidentiality of Alcohol and Drug Abuse Patient Records, the Federal Health Insurance Portability and Accountability Act (HIPPA), and the Mental Health and Developmental Disabilities Confidentiality Act (Illinois Civil Liberties 740 ILCS 110). The client must give his or her consent in writing for Illinois Valley Counseling Services, LLC to obtain or release any written or oral information concerning current or past medical, psychiatric, or addiction treatment.

EXCEPTIONS TO CONFIDENTIALITY REGULATIONS:

- 1) In life threatening situations or when a client's condition precludes the possibility of a written consent, pertinent medical information may be released to medical personnel responsible for the individual's care without the consent of the client, the guardian, or the clinician. The client and/or guardian is informed of what information was released as soon as possible after the event.
- 2) In situations involving state mandated reporting such as cases of suspected physical or sexual abuse or neglect of a child (this exception applies only to the initial reporting of the incident).
- 3) With an authorizing court order only if a) It is necessary to protect against a threat to life or of serious bodily harm, b) It is necessary to investigate or prosecute an extremely serious crime or, c) It is in connection with a proceeding at which the client has already presented evidence concerning confidential communications.

RIGHT TO CONFIDENTIALITY OF HIV / AIDS STATUS:

All information regarding HIV status, including any HIV testing, will not be documented in the client record. This information is not released to any other agencies or shared with any other Illinois Valley Counseling Services, LLC staff members without explicit authorization from the client to release such information.

- 1) This section does not apply to HIV and/or AIDS risk education and/or counseling, or other HIV and/or AIDS education which is provided to all individuals in DUI Risk Education classes.
- 2) An individual who wishes to be tested for HIV antibodies shall be informed that he or she may undergo testing on an anonymous basis at the local health department. No testing is conducted at the offices of Illinois Valley Counseling Services, LLC.

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RIGHT TO NOT BE DISCRIMINATED:

You have the right to not be discriminated against in any way on the basis of race, gender, national origin, religion, ancestry, age, economic condition, HIV status, sexual orientation, or disability. Every client has the right to be treated humanely and with dignity.

RIGHT TO TREATMENT IN THE LEAST RESTRICTIVE ENVIRONMENT:

Services at Illinois Valley Counseling Services, LLC are completely voluntary. You have the right to be treated in the least restrictive clinically appropriate setting. Any client consenting to treatment must agree to follow the conditions established by Illinois Valley Counseling Services, LLC for participation.

RIGHT TO INSPECT AND COPY YOUR MEDICAL AND BILLING RECORDS:

You have the right to inspect and obtain a copy of your information contained in our medical records. To request access to your billing or health information, contact the office manager. Under limited circumstance we may deny request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing, and supplies. You may be required to meet with your clinician to review such records prior to their release.

RIGHT TO ADD INFORMATION OR AMEND YOUR MEDICAL RECORDS:

If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request within 60 days, or some cases, within 90 days. Under certain circumstances, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the office manager. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

RIGHT TO AN ACCOUNTING OF DISCLOSURES:

You may request an accounting of any disclosures, if any, we have made related to your medical information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after April 14, 2007, please submit your request in writing to the Privacy Officer. We will notify you of the cost involved in preparing this list.

RIGHT TO REQUEST RESTRICTION ON USES AND DISCLOSURES OF YOUR HEALTH INFORMATION:

You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our office manager. However, we are not required to agree to such request.

RIGHT TO COMPLAIN:

If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Human Services. An individual will not be retaliated against for filing such complaint.

RIGHT TO EXPRESS OPINIONS AND RECOMMENDATIONS:

All clients are encouraged to express opinions and recommendations to any Illinois Valley Counseling Services, LLC staff member, either orally or in writing. You have the right to be assured that each written comment will receive the prompt attention and, on request, a prompt response from the Illinois Valley Counseling Services, LLC staff member.

RIGHT TO RECEIVE CHANGES IN POLICY

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

RIGHT TO REFUSE TREATMENT

You have the right to refuse treatment or any specific procedure and a right to be informed of the consequences resulting from such refusal.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS:

I / We have read and received a copy of the Notice of Privacy Practices and Client Rights Document.

Signature(s) _____ Date _____
(Patient signature 12 years or older)

Signature(s) _____ Date _____
(Parent / Legal Guardian)

CONSENT FOR TREATMENT OF CHILDREN AND OR ADOLESCENTS:

I / We consent that _____ may be treated as a client by
(Patient Name)

Illinois Valley Counseling Services, LLC. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children

Signature(s) _____ Date _____
(Parent / Legal Guardian)

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FEE SCHEDULE Effective February 1, 2019

ILLINOIS VALLEY COUNSELING SERVICES		
CPT CODE	SERVICE	FEE
90791	Psychiatric Diagnostic Evaluation	\$250/hour
90832	Psychotherapy (16-37 min.)	\$105
90834	Psychotherapy (38-52 min.)	\$140
90837	Psychotherapy (53+ min.) AUTH REQ	\$210
90847	Family Therapy	\$250
90853	Group Therapy	\$60
90839	Patient in Crisis 60 mins AUTH	\$210
90840	REQAdd on 30 min #_____	\$105
96699	Missed Appointment / Late Cancel Fee	\$75
	Phone Call (15 min)	\$55
	Deposition or Other Legal Involvement	\$300/hour
	Letter	\$100
	Records Release	\$50
	Written Evaluation	\$200

Based on information provided by your insurance company, your portion of the fee at the time of service is estimated to be:

Deductable Met / Deductable Not Met / Unknown

Initial Consultation \$ _____

Follow-Up Sessions \$ _____

This is merely an estimate and we cannot guarantee this is the final amount due.

Payment / Co-Pays are expected at the time of service.

