Jessica A. Sweet Therapy, LLC

Intake Form

- Date:
- Patient Name:
- Date of Birth:
- Preferred Name:
- Legal Gender:
- Home Address:
- Gender Identity and Preferred Pronouns:

| | May we leave a message? |
|---|---|
| • Home Phone Number: | [ ] Yes [ ] No |
| • Mobile Phone Number: | [ ] Yes [ ] No |
| • Can we text? | [ ] Yes [ ] No |
| • Email: | [ ] Yes [ ] No |

If the above patient is a minor complete the following:

- Name of Guardian:
- Address of Guardian:

May we leave a message?

- Guardian's Home Phone: [ ] Yes [ ] No
- Guardian's Mobile Phone: [ ] Yes [ ] No

Insurance and Referral

- If you will be using insurance to cover your sessions or a portion of the cost please complete the following and allow us to make a photocopy of your insurance card:

Primary Insurance Company:

- Who referred you to our office, or how did your learn about our practice?

## Emergency Contact Information

Name:

Relationship:

Phone Number:

## Presenting Problem

Please describe the current complaint or problem as specifically as you can, in your own words. How long have you experienced this problem, or when did you first notice it? What stressors may have contributed to the current complaint or problem?

## Previous Treatment

Have you received or participated in previous counseling and/or therapy?

[ ] Yes [ ] No

Summarize your goals for counseling/therapy:

**Credit Card Payment Form**

**Payment Information: Please Print in Black Ink**

I authorize Jessica A Sweet Therapy, LLC to charge my credit card for reoccurring payments/co-payments for counseling services, as well as for Late Cancellation fees as described in the Professional Disclosure Statement.

Type of Card: _____ Visa _____ MasterCard _____ Discover _____ American Express
Is this a FLEX SPENDING CARD or HEALTH SAVINGS ACCOUNT Card? : _____Yes _____No
Credit Card # _____ Exp Date _____
CVV# _____ (3-digit security code)
Cardholder's Name (Exactly as it appears on card):
_____
Billing Address: _____ Apt or Suite No _____
City: _____ State: _____ Zip:_____
Phone: _____
Signature of Cardholder: _____

***If the above listed card is attached to either a Flex Spending Account or Health Spending Account, please provide information for a secondary credit card. This secondary account will be charged if the payment is not approved by the FSA/HSA card, and it will also be used for any Late Cancellation fees as set forth in your counselor's Personal Disclosure Statement.***

Type of Card: _____ Visa _____ MasterCard _____ Discover _____ American Express
Secondary Credit Card # _____ Exp Date _____
CVV# _____ (3-digit security code)
Cardholder's Name (Exactly as it appears on card): _____
Billing Address: _____ Apt or Suite No _____
City: _____ State: _____ Zip: _____
Phone: _____
Signature of Cardholder: _____
Permission to use email address for receipts: _____ Yes _____ No
Preferred Email: _____

I authorize Jessica A Sweet Therapy, LLC to draft my credit card for counseling services including payments/copayments and/or Late Cancellation fees. I also authorize the provider to release any information acquired during treatment necessary to process claims. I also authorize Jessica A Sweet Therapy, LLC to send email receipts of payments made electronically.

Signature: _____ Date: _____

# Service Agreement

Welcome to Jessica A. Sweet Therapy, LLC. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

## Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

## Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

## Appointments

Appointments will ordinarily be 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time.

## Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other

professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Technology

We keep your files electronic and use a billing service that is all encrypted and HIPPA compliant. Normal e-mail servers are not encrypted so while ours are being sent to you, the return messages are not. Texting is also not HIPPA compliant. Please acknowledge this and are giving permission to break HIPPA in this format and communicate with you this way.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance. In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting the Therapist

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital or call 911.

At Jessica A. Sweet Therapy, we are committed to protecting the privacy and the confidentiality of your records. This notice has been prepared in response to federal regulations that enforce the Health Insurance Portability and Accountability Act of 1996 (HIPPA). The regulations contain legal requirements regarding how we must protect your health and service records.

Jessica A. Sweet Therapy provides service to any person or family regardless of age, gender, religion, disability, nationality, sexual orientation, race, ethnic or cultural group. We will make every effort to communicate with you in a familiar language and use communication technology to address difficulties in hearing and sight.

This Notice describes how medical, mental health and social service information about you may be used and disclosed and how you can get access to this information. Please review it carefully. It will help you understand you rights as recipient of services.

## CONFIDENTIALITY

We maintain a policy of strict compliance with State and Federal confidentiality laws including the Illinois Domestic Violence Act, DCFS Title 89 Confidentiality Rules, HIPPA, and the Mental Health and Developmental Disabilities Act 740 ILCS 110. No protected health and service information will be released to or requested from other persons, organizations, agencies or other third parties without your informed written consent, except in response to a court order or as otherwise required by law, and/or to protect you and others from injury, abuse or neglect.

## YOUR SERVICE INFORMATION RIGHTS

**To Review and Copy You Records**
You have the right to review your records with sufficient notice for as long as we maintain your record. Your record includes medical, mental health and billing records, as well as any other records we use in providing services to you. You are entitled to a copy of your records and may be charged a fee for copying and mailing. You may request that your information be released to anyone of your choosing. You may request that information be sent to alternative addresses and in alternative formats.

**To Obtain an Accounting of the Information Released From Your Record**
You have the right to request a list of the disclosures of your protected information that we have made outside of Jessica A. Sweet Therapy. Your request must be made in writing to the therapist at Jessica A. Sweet Therapy. The request must state the time period of the disclosures. You may request an accounting for disclosures made after April 14, 2003 and for a period of time not greater than six years.

**To Request Amendments to Your Records**
If you believe something in your record is incorrect or incomplete, you may request that it be amended. This request must be made in writing to your therapist at Jessica A. Sweet Therapy. Your request must state exactly what information is incomplete or inaccurate and your reasoning that supports your request. We will provide you with a timely response. We are permitted to deny your request if it is not in writing or does not include a reason to support the request. We may also deny your request if you ask us to amend information that:

- Was not created by Jessica A. Sweet Therapy, or if the person who created the information is no longer available to make the amendment.
- Is not a part of the information maintained by or for Jessica A. Sweet Therapy.
- We believe is accurate and complete

In cases where we deny a request, you may write a statement that you disagree with us. We will then add our response and your statement to the record. With your written permission, we will also make reasonable efforts to inform those people that have received the challenged information that an amendment has been made.

**To Request Restrictions**
You have the right to ask us to restrict or limit the information we use or disclose about you for delivery of services, payment or business operations. We are not required to agree to your request. If we do agree, we will comply with your request unless there is an emergency or we are otherwise required by law to disclose information.

**To Request Confidential Communications**
You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we only call you at work or by mail at a special address or post office box instead of your home address. Your request must be in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

## HOW WE MAY USE YOUR INFORMATION

**For Service Delivery**
We will use your protected health and service information to provide, coordinate, or manage the services we will provide to you. The minimum amount of protected information necessary to accomplish treatment goals may be disclosed to supervisors, other treatment team members, consultants, and administrators.

**For Payment**
Upon receipt of written consent, we may use and disclose you protected health and service information s that we can receive payment from you, your insurance company or other funding sources. The minimum amount of protected information will be disclosed to secure reimbursement for the services delivered to you. For example: we may disclose information that identifies you, your diagnosis and the services that you received.

**For Business Operations**
We may use your protected information to support our business activities and to improve the quality of our services. For example: we may use your records when evaluating the services you received. We may also disclose your protected information to health oversight and accrediting agencies and for activities authorized by law such as audits, investigations, inspections and licensure. Examples include the following:

**Governmental Entities**
We are required to share protected information with State and Federal governmental entities to determine our compliance with federal and state laws related to health care.

**Appointments and Communication**
We may contact you at the phone number you provided with regard to appointments, treatment and/or other issues that relate to the services you are receiving.

**Training and Fundraising**
Protected information that does not contain your personal identifiers may be disclosed for training and fundraising purposes.

**Business Associates**
There are some services provided by Jessica A. Sweet Therapy through a third party "business associate". Examples include financial auditors, answering services, and psychiatrists. Whenever service delivery to you requires the use or disclosure of your protected information, Jessica A. Sweet Therapy will have a written contract that contains terms to protect the privacy of your service information.

**For Reporting Child and Elder Abuse**
Staff with reasonable cause to believe that a child may be subjected to abuse or neglect are required by law to report this to the Illinois Department of Children and Family Services. Staff with reasonable cause to believe that an older person, who is incapable of seeking assistance because of some dysfunction, has been subjected to abuse or neglect are required by law to report this to the Illinois Department on Aging or one if its elder abuse provider agencies.

**For Reporting Risk of Harm to Clients and Others**
Staff with reasonable cause to believe that a risk exists of serious, immediate, physical or emotional injury or death may inform law enforcement agencies and person who may be affected by threatened action. Staff may also take steps to facilitate or secure the client's hospitalization, if warranted. Criminal activity on our premises may require the sharing of information with the law enforcement agencies.

**For Continuous Quality Improvement**
Continuous Quality Improvement (CQI) or "Peer Review" is another valuable process that Jessica A. Sweet Therapy uses to improve services. CQI activities may include the review of client records. Some of the findings may be published for use within and outside of Jessica A. Sweet Therapy but your name and other information that would identify you will not be used in any publications and reports.

**For Research**
We may use and disclose your protected information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

## CLIENT COMPLAINT AND GREIVANCE

Your rights of grievance are protected in accordance with The Illinois Medical Patient Rights Act 410 ILCS 50. There will be no retaliation or denial of service if you file a complaint.

If you believe that Jessica A. Sweet Therapy has violated your privacy rights, you may file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services at the following address:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave, Suite 240

Chicago, Illinois 60601
312-886-2359 or TDD at 312-353-5693

## CLIENT GRIEVEANCE PROCEDURES

Jessica A. Sweet Therapy provides internal procedures to address client complaints. We encourage you to express any concern about the services you receive to your service provider as soon as they arise. You can expect to have a satisfactory response from the provider of your service following a complaint. You can expect a written response from Jessica A. Sweet Therapy regarding your grievance. Jessica A. Sweet Therapy maintains grievance records for qualitative review.

## FUNDAMENTAL CLEINT RIGHTS

Jessica A. Sweet Therapy will not discriminate against a service recipient or applicant for services because of race, disability, color, creed, religion, sex, age, national origin, ancestry, citizenship, veteran status, and sexual orientation or other related factors and legally protected characteristics.

- Clients have the right to be free from abuse, neglect and exploitation
- Clients will have mental health services provided in the least restrictive setting.
- Clients have the right not to be denied, suspended or terminated from services or have services reduced by exercising any rights.
- Clients have the right to contact the public payer or insurer of payment regarding a grievance or complaint. An agency staff will assist clients to access appropriate resources and to facilitate contact.
- Clients have the right to accommodation for their disabilities as required by the American With Disabilities Act, section 504 of the Rehabilitation Ac and the Human Rights Act [755 ILCS 5]

**Access to Advocacy and Rights Organizations**
In order to safeguard your rights as a recipient of mental health and other services, staff is available to offer you assistance in contacting any of the following agencies regarding your concern about rights:

Equip for Equality
20 N. Michigan Ave, Suite 300
Chicago, IL 60602
312.341.0022
800.537.2632 (voice)
800.610.2779 (TTY)

Guardianship and Advocacy Commission
160 N. La Salle St
Suite 500
Chicago IL 60601
312.793.5900

Illinois Department of Human Services
401 S Clinton St
Chicago, IL 60607
1.800.843.6154

Illinois Department of Children and Family Services
100 W. Randolph St, 6th Floor
Chicago, IL 60601
312.814.4650

The U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201
Toll Free: 1.877.696.6775

**You may request a written copy of this notice at any time by contacting your therapist. Jessica A. Sweet Therapy reserves the right to change this notice based on changes in policy and applicable laws. Jessica A. Sweet Therapy will make every reasonable effort to notify recipients of services of any changes in the Privacy Policy.**

# Consent for Treatment and Acknowledgement of HIPPA

Your signature below indicates that you have been informed of the Service Agreement and agree to its terms. You are aware of the 24 hour cancelation policy, your rights as it pertains to HIPPA, and confidentiality.

Client Signature _____ Date_____

Guardian Signature of child age 12-17 _____ Date_____

Spouse Signature (if couple therapy) _____ Date_____