CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

PATIENT INFORMATION FORM

Today's date:	Primary Care Physician:

☐ PATIENT INFORMATION (A)

Client's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms. ❑ Other	Marital status (circle one) Single / Mar / Div / Sep / Wid / Other /

Is this your legal name?		If not, what is your legal name?	Social Security no.:	Birth date:	Gender:		
❑ Yes	❑ No			/ /	❑ M	❑ F	❑ Other

Street address:	Email:	Home Phone:
Line 1:	Preferred Method Of Contact? (Circle)	( )
Line 2:	Home / Cell / Text / Work / Email	Cell Phone:

City:	State:	Zip Code	
Employer:			Work Phone:
Employer Address:			( )

Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Website/Internet	❑ Yellow Pages	❑ Other	❑ Self-Pay Client?

☐ INSURANCE INFORMATION (B)

Is this patient covered by insurance? If yes, please complete below and provide a copy of an Insurance ID Card:

Primary Insurance Company:			
Subscriber's Name:	Birth Date:	Policy ID #:	Group #:
	/ /		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

Secondary Insurance Company: Applicable? ❑Yes ❑No				
Subscriber's Name:	Birth Date:	Policy ID #:	Group #:	
	/ /			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

☐ PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT(C)

If different than the patient, please complete below:

Responsible Party Name:					Birthdate: / /	Gender:	❑ M	❑ F	❑ Other
Responsible Party's relationship to patient:	❑ Self	❑ Spouse	❑ Child	❑ Other	Social Security #:				

Street address:	Personal E-mail:	Home phone #:
Line 1:		( )
Line 2:		Cell phone #:

City:	State:	Zip Code:	
Employer:			Work phone #:
Employer Address:			( )

☐ IN CASE OF AN EMERGENCY CONTACT PERSON: (D)

Name of local friend or relative (not living at same address):	Home phone #:	Cell/Work phone #:
	( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Counseling and Diagnostic Center. I understand that I am financially responsible for any balance not paid by insurance. I also authorize Counseling and Diagnostic Center of Woodfield or insurance company to release any information required to process my claims.

Parent / Guardian Signature:	Date: / /

FINANCIAL TERMS OF TREATMENT

1. 48 hour notice of cancellation is required. If cancellation is made after this time you will be charged a cancellation fee in the amount of $75.00. In case of an emergency, death in the family, hospitalization, illness, etc., please speak with your therapist regarding this fee.
2. The undersigned agrees that, in consideration of the services to be rendered to the patient, he/she agrees to pay The Counseling and Diagnostic Center of Woodfield, Ltd. in accordance with the regular fees and terms as outlined.
3. Any insurance claim submitted to an insurance carrier that is denied due to a billing error will be corrected and resubmitted at the expense of The Counseling and Diagnostic Center of Woodfield, Ltd. Any insurance claim denied due to a patient/guarantor error (incorrect policy information, etc.) will be subject to a claim denial fee in the amount of $5.00 per claim. If denied claim is correctable and payable upon resubmit the denial fee will be waived. Claim will be subject to a claim resubmit fee in the amount of $2.50 per claim.
4. Should the account be referred to an agency or attorney for collection, the undersigned will pay for all attorney fees and will be responsible for all collection expenses. The undersigned shall also be held responsible for all interest after 60 days, at the rate of 1.5% of the unpaid monthly balance.
5. In the instance of failure to comply with these obligations, each consents to the disclosure of their identity and other necessary information relating to the services rendered to the patient by the attending counselor, clinic, or attorney for the purpose of enforcing the patient's or guarantor's obligations to the attending counselor or collection agency or attorney. Such disclosure or re-disclosure shall not be deemed to be a breach of the patient's confidentiality by the attending counselor/psychotherapist or clinic.

I authorize The Counseling and Diagnostic Center of Woodfield Ltd. to release any information including the diagnosis and the records of any treatment of examination required to the above named patient during the period of such care to the third party payor for the sole purpose of obtaining payment for services rendered to the patient by The Counseling and Diagnostic Center of Woodfield. Ltd.

I authorize and request that my insurance company pay directly to The Counseling and Diagnostic Center of Woodfield, Ltd. all insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual fee for service billed. I agree to be responsible for all fees for service not paid by my insurance carrier for services rendered on behalf or myself, or my dependents, unless prohibited by contract.

I have read and understand the above information and agree to these conditions.

X_____/_____/_____

Signature of patient or responsible party/guarantor Date

X_____/_____/_____

Signature of witness Date

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

ADULT

A SEPARATE FORM IS REQUIRED FOR EACH ENTITY

AUTHORIZATION FOR RELEASE/EXCHANGE OF PATIENT INFORMATION

I hereby authorize:

Counseling and Diagnostic Center of Woodfield, Ltd.
955 N. Plum Grove Road, Suite C
Schaumburg, Illinois 60173
Telephone: (847) 884-0210
Facsimile: (847) 884-7349

to use, disclose to, release and/or exchange mental health and medical information, records, and communications obtained during the course of treatment from:

_____/_____/_____ to _____/_____/_____
[insert approximate dates of service]

regarding _____ whose date of birth is: _____/_____/_____
[Patient Name]

1. The information is to be disclosed/exchanged with the following:

_____

_____

_____

2. Description of Information to be Used or Disclosed:

The information to be used, obtained by, or disclosed by/to Counseling and Diagnostic Center of Woodfield, Ltd.(CDCW) includes only those items checked below. I understand that this Authorization extends to all or any part of the records/information designated below which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. This Authorization is limited to only that information indicated below to be disclosed to or by CDCW. I hereby release CDCW from any and all legal responsibility or liability that may arise from the use or disclosure of medical or other records and other health information in reliance on this Authorization. (Patient should initial each item to be disclosed).

_____ Psychological Testing
_____ Consultation Reports
_____ Medication Records
_____ Discharge Summary
_____ Presence/Participation in Therapy
_____ Physician Orders
_____ Progress/Psychotherapy Notes
_____ Clinical Aftercare Plan
_____ Drug/Alcohol History
_____ Other:

_____ Mental Status Exam
_____ Education - Clinical Progress
_____ Education – IEP/504 Plans
_____ Education – School Assignments/Assessments
_____ Psychiatric Evaluation
_____ Physician Progress Notes
_____ Treatment Plans/Treatment Summaries
_____ Laboratory Data
_____ Recommendations
_____ Verbal Communications Only (Limited Disclosure)

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

ADULT

A SEPARATE FORM IS REQUIRED FOR EACH ENTITY

3. Purpose of the Use or Disclosure is for:

- ☐ Continuity of Treatment
- ☐ Family Involvement
- ☐ Consultation
- ☐ Referral
- ☐ At the request of the patient and/or legal guardian
- ☐ Other: _____

4. Expiration:
I understand that unless I revoke this Authorization earlier, this Authorization will automatically expire on: _____/_____/_____.
[Insert calendar date]

5. Redisclosure:
I understand that information used or disclosed in accord with this Authorization may no longer be protected by federal or state law and could be used or redisclosed by the receiving party, pursuant to any agreement I may have with such party.

6. Refusal to Consent:
I understand that I may refuse to sign this Authorization and the result would be that the mental health records and/or communications would not be disclosed.

7. Certification:
The undersigned affirms that I am (check whichever applies):

- ☐ The client and the identification that I have provided is true and correct.
- ☐ The client's authorized representative, and that the identification and proof of authority that I have provided is true and correct. My relationship to the client is that of:
  _____ Guardian _____ Other: _____

8. Revocation:
I have the right to revoke this Authorization at any time if I do so in writing, although I understand that I cannot do anything about information already used or disclosed pursuant to this Release of Information.

9. Copy Received:
I understand that I will receive a copy of this completed form upon request.

10. Right to Inspect and Copy:
I understand that I have the right to inspect and copy the information to be disclosed.

11. Effect of Copies:
I intend that fax, copies, or electronic versions of this document shall carry the same force and effect as the original.

12. Alcohol/Substance Abuse Files:
If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse client.

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

ADULT

A SEPARATE FORM IS REQUIRED FOR EACH ENTITY

Date	Patient Signature	Printed Name
Date	Witness to Patient Signature	Printed Name
Date	Personal Representative Signature (Guardian or Other Authorized Agent)	Printed Name
Date	Witness to Personal Representative Signature	Printed Name

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

Your Information.
Your Rights.
Our Responsibilities.

This Notice of Privacy Practices is effective as of September 18, 2020.

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

YOUR RIGHTS: You have the right to:

- Get a copy of this privacy notice
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we have shared your information
- Choose someone to act for you
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- File a complaint if you believe your privacy rights have been violated

➢ *See **Pages 2 & 3** for more information on these rights and how to exercise them*

YOUR CHOICES: You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Provide mental health care

➢ *See **Pages 5 & 6** for more information on these choices and how to exercise them*

OUR USES & DISCLOSURES: We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a coroner/medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *See **Pages 3-5** for more information on these uses and disclosures*

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information ("PHI"). We will not use or disclose your protected health information other than as described here unless you provide written authorization. You may revoke your authorization at anytime, in writing, but only as to future uses or disclosures and only when we have not already acted in reliance on your authorization.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Please feel free to contact our Privacy Officer with any questions.

Your Rights

- **When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

Right to Obtain a Copy of this Notice of Privacy Practices

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Right to Request Confidential Communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Right to Request a Restriction on Certain Uses and Disclosures

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information relating solely to that item or service for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Obtain an Accounting of Disclosures of Your Protected Health Information

- You can ask for a list (accounting) of the times we have shared your health information for six (6) years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one accounting per year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months.

Right to Choose Someone to Act for You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Right to Inspect and Request an Electronic or Paper Copy of Your Medical Record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Request a Correction to Your Medical Record

- You can ask us to correct health information about your protected health information that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Right to Receive Notice of a Breach

- You have the right to be notified in writing following a breach of your protected health information that was not secured in accordance with security standards as required by law.

Right to File a Complaint

- You can complain if you feel we have violated your rights by contacting our Privacy Officer, David Jezl, Psy.D. at: (847) 884-0210, ext 201 or by mail to **Counseling and Diagnostic Center of Woodfield, Ltd., 955 N. Plum Grove Road, Suite C, Schaumburg, Illinois 60173.**
- You also have the right to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Our Uses & Disclosures

- **How do we typically use or share your health information?** We may use and share your health information for the following purposes:

  Treatment: We can use and disclose your health information to provide treatment, and to coordinate care, or manage your healthcare and any related services by sharing it with other professionals, an integrated health system, or a member of an interdisciplinary team who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

  Run Our Organization/Healthcare Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We may use your health information to conduct quality assessment and improvement activities and to manage your treatment and services.*

  Payment: We can use and share your health information to bill and obtain payment for our health care services from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

  Business Associates: We may disclose your health information to our third-party business associates (*for example, a billing company or accounting firm*) that perform activities or services on our behalf. Business associates must agree in writing to protect the confidentiality of your information. *Example: We may use or disclose your health information to a business associate that we use to provide reminders to you of an upcoming appointment.*

- **How else can we use or share your health information?** We may be allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The following are other uses and disclosures we make of your health information without your authorization, consent or opportunity to object: (For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

  Required by Law: We may share information about you to the extent that is required by federal, state, or local laws under the circumstances provided by such law; this includes with the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law.

  Health Oversight Activities: We may use and disclose your health information to state agencies and federal government authorities, or to a health oversight agency, for activities authorized by law such as audits, administration or criminal investigations, inspections, licensure, accreditation or disciplinary action and monitoring compliance with the law, including in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. The Illinois Mental Health and Developmental Disabilities Confidentiality Act allows for the unconsented disclosure of your health information to a health information exchange (HIE), which oversees the electronic exchange of health information, for HIE purposes. *See* 740 ILCS 110/9.5.

  Public Health & Safety: We may use or disclose your health information in certain situations, such as in order to prevent/report communicable diseases, helping with product recalls, reporting adverse reactions to medications, to prevent or reduce a serious threat to anyone's health or safety, and for work place surveillance or work-related illness and injury.

  Research: We may disclose your health information for health research.

  Worker's Compensation, Law Enforcement, & Other Governmental Requests: We may disclose your health information as authorized to comply with worker's compensation claims, for law enforcement purposes or with a law enforcement official, and for special government functions, such as military, national security and presidential protective services.

  Abuse, Neglect or Domestic Violence: We may disclose your health information to the designated public agency that is authorized by law to receive reports of child or elder abuse, neglect, or domestic violence. This disclosure will be made consistent with the requirements of applicable federal and state laws.

  Coroner/Medical Examiner: We may disclose your health information to a coroner/medical examiner or funeral director for an investigation of a death and/or homicide, identification purposes, determining cause of death or for the coroner to perform other duties authorized by law.

Lawsuits & Legal Proceedings: We can share health information about you in response to a valid court or administrative order, or in response to a subpoena, to the extent that such disclosure is authorized and permissible under the *Illinois Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/1 *et seq.*

Your Choices

- **Your Choice. For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, please let us know. Please share with us what you want us to do, and we will follow your instructions. If you are not able to tell us your preference (for example, if you are unconscious), we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
  In the following cases, you have the right and choice to tell us to:
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - If your health information is accessible through the HIE, you may provide a written request to opt-out of further disclosure by the HIE to third parties, except to the extent permitted by law (See www.hie.illinois.gov for information on opting-out)
- **Written Authorization.** Any other uses and disclosures of your health information not described in this Notice will be made only with your written authorization. Disclosures requiring your written authorization include:
  - Subject to exceptions, uses and disclosures of your health information for marketing purposes
  - Disclosures that constitute a sale of your health information
  - Most uses and disclosures of psychotherapy notes

Other Information

- **Changes to the Terms of this Notice:** We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. *The effective date of this Notice of Privacy Practices is* ***September 18, 2020****.*
- **Other Instructions for Notice:** We further comply with the following state and federal laws and regulations related to the disclosure of your protected health information:
  - **Mental Health Records and Communications Disclosure:** We comply with the provisions of the *Illinois Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/1 *et seq.* and the *Illinois Mental Health and Developmental Disabilities Code*, 405 ILCS 5/1 *et seq.*
  - **Alcohol/Substance Abuse Records Disclosure:** We comply with the federal Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 *et seq.* If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by federal confidentiality rules, and such information is prohibited from further disclosure without express permission by written consent of the person to whom it pertains or as otherwise permitted by Federal Rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient. *See* 42 U.S.C. § 290dd-3 and § 290ee-3; 42 C.F.R. Part 2 *et seq.*; *and* 20 ILCS 301 *et seq.*
- **This Notice of Privacy Practices applies to the following entities:** This Notice of Privacy Practices applies to Counseling and Diagnostic Center of Woodfield, Ltd. and its providers.

OUR CONTACT INFORMATION:
Counseling and Diagnostic Center of Woodfield, Ltd.
955 N. Plum Grove Road, Suite C
Schaumburg, Illinois 60173

PRIVACY OFFICER: David Jezl, Psy.D.
Office: (847) 884-0210, ext 201
Fax: (847) 884-7349
E-mail: counselinganddx@aol.com

CDCW

COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

Acknowledgment of Privacy Practices

I, _____, whose date of birth is ____/_____/_____

hereby acknowledge that I have been given and received an opportunity to read a copy of Counseling and Diagnostic Center of Woodfield, Ltd.'s HIPAA Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Counseling and Diagnostic Center of Woodfield, Ltd., at: (847) 884-0210, ext. 201.

_____ _____

Signature of Patient/Client **Date**

_____ _____

Signature or Parent, Guardian, Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (*e.g.,* power of attorney, healthcare surrogate, etc.) and provide a written copy of said authority.

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____ _____

Signature of Staff Member **Date**

CDCW

COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

INFORMED CONSENT

Welcome to the Counseling and Diagnostic Center of Woodfield, Ltd. This document contains important information about the professional services and business policies of this clinic. Please read it carefully and note any questions you might have so that we can discuss them at our initial meeting. By signing below, you agree to the policies contained herein. Upon the completion of the first session, your therapist will request that you sign this document. Please review it accordingly prior to the session.

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It does call for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about during therapy sessions and while you are at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

If you have questions about our clinic's procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a referral.

SESSIONS

Appointments are most frequently scheduled for one 60-minute (one appointment hour of 53 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled you must provide 48 hours advance notice of cancellation, or you will incur a $75 cancellation/no show fee. We do understand that there may be mitigating circumstances which cause you to unexpectedly miss a session. Should that occur, we may agree that you were unable to attend due to circumstances beyond your control. If that occurs, another time to reschedule the appointment can be made and you will not be charged the cancellation/no show fee.

PROFESSIONAL FEES

The CDCW hourly fee will apply unless we have set a different fee prior to the meeting, in which case that fee will apply. The clinic's standard fee per 60-minute session for individual therapy is $200.00. The fee for a therapy session that is less than the standard 60-minute session (*e.g.*, a 45-52 minute therapy session) is $160.00. If we are under contract with your insurance company, our fees are governed by the contract and you are responsible for co-pays/patient responsibility as outlined by your insurance carrier. Any fees, outside of the portion covered by insurance (if being billed by us), are due at time of service.

Additionally, the same fee, $200/hour, is charged for other professional services you may need. We break down the hourly cost of work for periods of less than one hour in quarter hour increments (*e.g.*, 15, 30 and 45 minute increments of time). We will discuss areas in which payment may be required for professional services other than therapy sessions as they arise. These additional costs are discussed below.

Other services may include, but are not limited to, report writing, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, collaboration with schools or other professional providers, and the time spent performing any other service you may request. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for their professional time even if the therapist is called to testify by another party. Due to the nature and complexity of legal proceedings and involvement thereof, our fee is $250/hour for both preparation and attendance at any legal proceeding, including travel to and from any meetings as well as time incurred for the therapist's consultation with legal counsel.

INSURANCE REIMBURSEMENT

In order for us to set treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have an active health insurance policy, it will usually provide some coverage for mental health treatment. We have an insurance information form available that you are required to fill out and periodically update regarding your insurance coverage. CDCW does routinely submit billing to patients' health insurance companies for services rendered. While CDCW will provide you with whatever assistance we can to help secure the insurance benefits to which you are entitled, you (not your insurance company) are responsible for the full payment of our fees. Therefore, it is very important that you find out exactly what mental health services your insurance policy covers.

You should also be aware that most insurance companies require you to authorize CDCW to provide them with a clinical diagnosis. Sometimes we may have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in very rare cases). This information will become part of the insurance company files and will probably be stored electronically. Though all insurance companies are required to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it. By signing below, you agree to hold us harmless from any liability or legal responsibility that may arise from the use or disclosure of medical information to your health insurance carrier. We will do our best to keep you apprised of any requests for information from your health insurance company.

It is important to remember that you always have the right to pay for our clinical services yourself to avoid disclosure to your insurance company as described above [unless prohibited by your insurance contract]. If you do NOT want your insurance billed for services, please make that clear to your therapist as soon as possible, as we usually submit billing on the day of service.

CONTACTING YOUR THERAPIST

Your therapist is often not immediately available by telephone. When unavailable, clinical staff's extensions provide voicemail that is monitored frequently. We make every effort to return your call on the same day, except for weekends and holidays. Your therapist may call late in the evening, so let them know if that is a problem. If you are difficult to reach, please provide several times when you will be available. If you are unable to reach your therapist and your call is of an urgent nature, an emergency number to reach them is provided on the voicemail. In the rare instance you do not get a response, you may wish to place another call/text message. If your therapist will be unavailable for an extended time, they will provide you with the name of a colleague to contact, if needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that treatment records are maintained for all patients. You are entitled to receive a copy of your records, or a summary can be prepared for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in the presence of your therapist so that they can discuss the contents with you. You will be charged an appropriate fee for any professional time spent in responding to information requests or reviewing the contents of your file with you.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a therapist is protected by law. Information about your therapy, or therapy with your child, cannot be disclosed/released to others without your written permission. In the case of minors, those between the ages of 12-17 years of age must authorize the release of their mental health records and communication in addition to a parent/guardian (see below). However, there are a few exceptions.

In most legal proceedings, you have the right to prevent any information about your treatment and mental health records from being disclosed. The courts very much support therapist/patient confidentiality. However, in some proceedings (*e.g.,* involving child custody and those in which your emotional condition is an important issue), a judge may order your treating therapist's testimony if he/she determines that the issues demand it. CDCW therapists will not participate in legal proceedings without a valid, mental health law compliant subpoena.

If there is reason to believe that a child, elderly person or disabled person is being abused, a report must be made with the appropriate state agency. Pursuant to the Illinois Abused and Neglected Child Reporting Act (ANCRA), therapists are "mandated reporters" who are required to report to the Illinois Department of Children and Family Services (DCFS) when they have *reasonable cause* to believe that a child known to them in their professional or official capacity is an abused or neglected child. If a call is placed, DCFS may investigate the situation, which may include speaking with the therapist, the child and the parent/guardian. If such a mandated report is to be made, it is CDCW policy to, *when possible*, first advise the patient/guardian that DCFS will be contacted. A therapist has immunity from any criminal or civil liability in the event that such a report is made in good faith, **even when made without the consent of the patient.**

If a patient threatens to harm himself/herself or someone else, the treating therapist may be obligated to seek hospitalization for the patient or to contact family members or others who can help provide protection. The above situations have rarely occurred in this practice. If such a situation occurs, every effort will be made to fully discuss it with you before taking any action.

Clinical therapists occasionally find it helpful to consult with other professionals about a case. During a consultation, every effort is made to avoid revealing the identity of the patient. The consultant is also legally bound to keep the information confidential. Although the therapist can discuss the provision of mental health services to you with the therapist's supervisor, a consulting therapist, members of a staff team participating in the provision of mental health services, with an interdisciplinary team, or with the therapist's legal counsel without your consent, this information can only be disclosed to the extent that knowledge of your mental health records or communications is essential to the purpose for which the disclosure is made *and* only after you are informed that such disclosure may be made.

While this written summary references some, but not all of the statutory exceptions to maintaining confidentiality and should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have. Your therapist will be happy to discuss these issues with you if you have any specific questions, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and CDCW therapists are not attorneys.

PATIENTS UNDER THE AGE OF 18 YEARS

If you are under 18 years of age, please be aware that the law provides your parents the right to have access to your mental health records and communications. Additionally, if you are between the ages of 12-17, we are required to seek your permission before we release any of your mental health records or communications to your parents or to a third party, unless your therapist feels there is a compelling reason to deny access to your mental health records and communications. If you do not consent to the release of your mental health records or communications to your parent/guardian, only general information about your treatment will be provided to them. However, disclosure of information may be necessary and/or mandated if your therapist has reasonable cause to believe that you are being harmed, or if there is a clear and imminent risk that you will seriously harm yourself or someone else. In those instances, you and your parents will be notified of such concern, and other notifications to designated agencies as mandated by IMHDDCA and/or ANCRA would be provided. A summary of your treatment may be provided to your parent(s) when it is complete. Before giving them any specific information, it will be discussed with you. Your therapist will work to best handle any objections you may have with what is to be discussed.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Signature of Patient (12 years or older)	*Date*
Signature of Witness	*Date*
Signature of Parent/Guardian (if Patient is under 18)	*Date*
Signature of Clinician	*Date*

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

UNIVERSAL MEDICATION FORM

Date form started: ____/____/_____

Name:	**Address:**
Phone Number:	
Birth Date:	
Emergency Contact/Phone Numbers:	
IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)	
Tetanus	Flu Vaccine(s)
Pneumonia Vaccine	Hepatitis Vaccine
Other:	
Allergic To/Describe Reaction	

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as need (example: nitroglycerin).

Date	Name/Dose	Doctor's Name and Reason for Taking	Comments	Date Stopped

Some medications may impact your mental health treatment. For coordination of care, it may be necessary for your therapist to contact your prescribing doctor. Attached in this paperwork is a release of information. Please complete it with your physician's name and phone number.

CDCW
COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD.

FINANCIAL AGREEMENT - RECURRING

TO BE COMPLETED BY CLIENT AND/OR THE RESPONSIBLE PARTY

CLIENT NAME: **DATE OF BIRTH:** / /

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

RESPONSIBLE PARTY NAME: **DATE OF BIRTH:** / /

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

TO BE COMPLETED BY THE CREDIT / DEBIT CARD HOLDER

CARD HOLDER NAME:

ADDRESS: **UNIT #, ETC.:**

CITY: **STATE:** **ZIP:**

CREDIT CARD #:

EXPIRATION DATE: **TYPE:** AMEX | DISC | VISA | MC |OTHER

- I AUTHORIZE THE COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD, TO PROCESS PAYMENTS TO THE CREDIT CARD OFFERED ABOVE.

☐ **FOR ALL CO-PAYMENTS DUE AT THE TIME OF SERVICE.**
THIS IS TO BE PROCESSED THE FOLLOWING BUSINESS DAY BY THE CDCW BILLING DEPARTMENT.

-OR-

☐ **FOR ALL ACCOUNT ACCUMULATIONS DUE AT THE END OF EACH MONTH**
THIS PAYMENT IS TO BE PROCESSED ON THE LAST FRIDAY OF EACH MONTH.

- I AUTHORIZE PAYMENT TO BE PROCESSED THE FOLLOWING BUSINESS DAY AFTER EACH SESSION HELD.
- I UNDERSTAND THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS WRITTEN NOTIFICATION IS RECEIVED BY THE COUNSELING AND DIAGNOSTIC CENTER OF WOODFIELD, LTD, NOTIFYING OF A REQUEST TO TERMINATE THIS RECURRING COPAYMENT AGREEMENT.

CLIENT, RESPONSIBLE PARTY SIGNATURE **DATE**

CARD HOLDER SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

FOR INTERNAL USE ONLY - **ACCOUNT #**											**Processed By:**	

955 N. Plum Grove Road, Suite C, Schaumburg, IL 60173 Ph(847)884-0210, Fax(847)884-7349
www.cdcwoodfield.com