



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:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> 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:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No					/ /	
Street address:				Email:		Home Phone:	
Line 1:				Preferred Method Of Contact? (Circle)		()	
Line 2:				Home	Cell / Text	Work	Email
City:		State:	Zip Code				()
Employer:						Work Phone:	
Employer Address:						()	
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.			<input type="checkbox"/> Insurance Plan
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Website/Internet		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other	<input type="checkbox"/> Self-Pay Client?	
<input type="checkbox"/> Hospital							

☐ 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:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Secondary Insurance Company:							
Applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Subscriber's Name:		Birth Date:	Policy ID #:				Group #:
		/ /					
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

☐ PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT(C)

If different than the patient, please complete below:

Responsible Party Name:				Birthdate: / /		Gender:	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Other
Responsible Party's relationship to patient:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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 of 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

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	_____ Mental Status Exam
_____ Consultation Reports	_____ Education - Clinical Progress
_____ Medication Records	_____ Education – IEP/504 Plans
_____ Discharge Summary	_____ Education – School Assignments/Assessments
_____ Presence/Participation in Therapy	_____ Psychiatric Evaluation
_____ Physician Orders	_____ Physician Progress Notes
_____ Progress/Psychotherapy Notes	_____ Treatment Plans/Treatment Summaries
_____ Clinical Aftercare Plan	_____ Laboratory Data
_____ Drug/Alcohol History	_____ Recommendations
_____ Other:	_____ Verbal Communications Only

3. Purpose of the Use or Disclosure is for:

- | | |
|--|--|
| <input type="checkbox"/> Continuity of Treatment | <input type="checkbox"/> Referral |
| <input type="checkbox"/> Family Involvement | <input type="checkbox"/> At the request of the patient and/or parent and/or legal guardian |
| <input type="checkbox"/> Consultation | <input type="checkbox"/> 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:
_____ Parent _____ 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.



COUNSELING AND DIAGNOSTIC
CENTER OF WOODFIELD, LTD.

CHILD

**A SEPARATE
FORM IS
REQUIRED FOR
EACH ENTITY**

Date

Client Signature - age 12 and older

Printed Name

Date

Witness to Client Signature

Printed Name

Date

Personal Representative Signature
(Parent, Guardian, or Other Authorized Agent)

Printed Name

Date

Witness to Personal Representative Signature

Printed Name

**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



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



COUNSELING AND DIAGNOSTIC
CENTER OF WOODFIELD, LTD.

Child and Adolescent Services Contract

The undersigned, parent(s)/guardian(s) of _____,
[Patient name]

acknowledge that my/our child is a patient of Counseling and Diagnostic Center of Woodfield, Ltd.

Prior to beginning treatment, it is important for you to understand your clinician's approach to therapy with minors and agree to some rules about your child's confidentiality during his/her treatment. The information contained herein is in addition to the information contained in Counseling and Diagnostic Center of Woodfield, Ltd.'s Informed Consent. We are legally and ethically obligated to provide you with informed consent regarding your child's mental health treatment. As we go forward, you will be reminded of important issues as they arise.

One risk of child therapy involves disagreement between parents and/or disagreement between parents and your child's therapist regarding the best interests of the child. If such disagreements occur, your therapist will strive to listen carefully so that your perspectives are understood, and the clinician will work to explain his/her perspective/rationale. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If you decide that therapy should end, we will honor that decision, however we ask that you allow the option of having at least one closing session to appropriately end the treatment relationship (assuming a longer rather than short-term therapy relationship is established).

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between the child and his/her parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. However, this is not meant to, in any way, exclude you from, or leave you out of the process of your child's treatment. It helps promote progress by providing a secure, trusting environment in which your child can speak, as well as promoting your child's legal right to privacy. In the State of Illinois, minors over the age of 12 are given the right to consent to the release of their mental health records.

It is our policy to provide you with general information about your child's treatment status. Your child's therapist will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. Your child's therapist will not share with you the specifics of what your child has disclosed in session without your child's consent. At the end of your child's/teen's treatment, your child's therapist will meet with you to summarize what issues were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If your child is of adolescent age but still a minor (under 18 years of age) and attends on his/her own, you will be informed if he/she does not attend sessions. If it is ever believed that your child is at clear and imminent risk of harming him/herself or another, you will be informed by his/her therapist and other necessary authorities may be informed as well.

Additionally, the Illinois Abused and Neglected Child Reporting Act (ANCRA) requires that “mandated reporters” contact the Illinois Department of Children and Family Services (DCFS) when the therapist has **reasonable cause** to believe that a child known to him/her in his/her professional or official capacity is an abused or neglected child. Mental health practitioners are mandated reporters. If child abuse or neglect suspected, the law **absolutely requires** that a phone call be made to DCFS, and DCFS will determine whether the situation warrants an investigation. The statute also provides the mandated reporter with immunity from any criminal or civil liability in the event that such a report is made in good faith, **even without the consent of the patient.**

Although our responsibility to your child may require involvement in conflicts between the two parents, we require your agreement that our involvement will be strictly limited to that which will benefit your child. This means, among other things, that each of you will treat anything that is said in session with the therapist as confidential. By signing below, you both also agree that neither of you will attempt to gain advantage in any domestic legal proceeding from the therapist’s involvement with your child. In particular, we ask that in any such proceedings, neither of you will ask the therapist to testify in court, whether in person, through a deposition, by completing a written summary solely for the use in the court proceedings, or by affidavit. We also request that you instruct your attorneys not to subpoena your child’s therapist or to refer in any court filing to anything they have said or done. As a child’s therapist, we are not custody evaluators and ethically cannot put ourselves in that role.

Please note that this agreement may not prevent a judge from requiring testimony, and if your child’s therapist is required to testify, they are ethically bound to provide information regarding your child’s mental health treatment, not to give their opinion about either parent’s custody or visitation suitability. If the court appoints a custody evaluator, guardian *ad litem*, or parenting coordinator, your child’s therapist will provide information as needed (only if appropriate releases are signed or a court order is provided), but will not make any recommendations about the final decision. Furthermore, if a therapist is required to appear as a witness in any format, the party responsible for their participation agrees to reimburse Counseling and Diagnostic Center of Woodfield, Ltd. at the rate of \$250 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs including consultation with Counseling and Diagnostic Center of Woodfield’s attorneys.

The signature(s) below indicate(s) I/we understand and agree to abide by the above terms and conditions. By signing, I/we am/are also confirming that I/we have the legal standing (guardianship, significant decision-making authority regarding medical/health/mental health treatment decisions) to consent to the above-named minor child’s mental health treatment.

Signature of Parent/Guardian)

Date

Signature of Witness

Date

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

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, ginkgo). 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.



COUNSELING AND DIAGNOSTIC
CENTER OF WOODFIELD, LTD.

SOCIAL-DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____ Age: _____ Grade: _____

Person providing information: _____ Relationship to child: _____

Who does child live with (please check one): ☐ Both Parents ☐ Mother ☐ Father ☐ Other (specify) _____

Biological Father's Name: _____ Occupation: _____ Years education: _____

Biological Mother's Name: _____ Occupation: _____ Years education: _____

If applicable, Guardian's Name _____ Occupation: _____ Years education: _____

Primary Language of Caretaker: _____ Primary Language of Child: _____

Are biological parents of child currently: ☐ Married ☐ Separated ☐ Divorced ☐ Never Married

• If separated or divorced, who has *legal* custody? ☐ Mother ☐ Father ☐ Other (specify) _____

• If separated or divorced, how do you feel your child has adjusted to the separation/divorce? _____

Are there other adults who have a significant part in raising your child? ☐ Yes ☐ No

• If yes, please indicate name & relationship (step-parent, grandparent, boy/girlfriend, etc.) _____

Who currently lives with the patient? Attach additional sheets as needed.

Name	Age	Relationship	Occupation/Grade

What do you feel are your child's strengths? _____

What do you feel are your child's weaknesses? _____

What are your current concerns about the patient? What prompted you to seek services?

Concern	When concern developed

II. HEALTH AND DEVELOPMENT

A. Pregnancy and Birth

Is your child: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other (specify) _____

Mother's age at birth? _____ **Did mother receive routine medical prenatal care?** ☐ Yes ☐ No

List any prescription medications, alcohol, nicotine or drugs taken during pregnancy: _____

Please check the conditions below that describe the health of the child and mother:

Mothers Pregnancy	Child's Delivery	Child's Condition at Birth
<input type="checkbox"/> No complications	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> Blackouts	<input type="checkbox"/> Induced labor	<input type="checkbox"/> Lack of oxygen
<input type="checkbox"/> Falls	<input type="checkbox"/> C-section	<input type="checkbox"/> Breathing problem
<input type="checkbox"/> Physical injury	<input type="checkbox"/> Breech birth	<input type="checkbox"/> Birth injury/defect
<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Unusually long labor (>12 hours)	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Premature # of weeks _____	<input type="checkbox"/> Premature # of weeks _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Overdue # of weeks _____	<input type="checkbox"/> ICU # of days _____
<input type="checkbox"/> Emotional stress	<input type="checkbox"/> Other problem (specify)	<input type="checkbox"/> Other problem (specify)
<input type="checkbox"/> Toxemia		
<input type="checkbox"/> Alcohol and/or drug use		
<input type="checkbox"/> Use of tobacco		
<input type="checkbox"/> Other problem (specify)		

Was the child considered full term? ☐ Yes ☐ No **If no, how many weeks?** _____

Child's birth weight: _____ pounds _____ ounces

How long was the child in the hospital after delivery? _____

List any interventions required for the child after birth (phototherapy, oxygen, etc.): _____

Did the child's mother or other primary caretaker experience depression or anxiety in the first two years of the child's life? ☐ Yes ☐ No

If applicable, Adoption History

Was the Patient adopted? ☐ Yes ☐ No *(if no, skip to "B. Health History")*

Where was the child born? _____ **At what age was the child adopted?** _____

How many home placements/homes has the child had in his/her lifetime? _____

Is the child aware that he/she is adopted? ☐ Yes ☐ No

Does the child have contact with his/her biological mother and/or father? ☐ Yes ☐ No

B. Health History

Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your child currently taking any medication? ☐ Yes ☐ No

• If yes, please list medications and uses: _____

Has your child had any of the following?

Please check all that apply.	Please describe and give details, dates, and/or age of onset
<input type="checkbox"/> Allergies	
<input type="checkbox"/> Appetite Changes	
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Bedwetting	
<input type="checkbox"/> Emergency Room Visits	
<input type="checkbox"/> Head Injury	
<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> History of Ear Infections	
<input type="checkbox"/> Hospitalizations	
<input type="checkbox"/> Loss of Consciousness	
<input type="checkbox"/> Respiratory Disease	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Sleep Difficulties	
<input type="checkbox"/> Surgery	
<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Vision Problems	
<input type="checkbox"/> Other (please specify) _____	

C. Developmental Milestones

Please indicate the age or range when your child performed the following milestones (check 1 box per row):

Milestone	0-3 months	4-6 months	7-12 months	13-18 months	19-24 months	2-3 years	3-4 years	Other (specify age)
Sat without support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walked alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walked up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spoke first word	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spoke 2-3 word phrases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spoke in sentences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fully bladder trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fully bowel trained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stayed dry all night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Child's current level of speech: ☐ No Words ☐ Few Words (<10) ☐ 2-3 word phrases daily ☐ Fluent speech

Have you ever been concerned that your child lost skills after meeting certain milestones (that is, lost speech, eye contact, motor skills, etc.)? ☐ Yes ☐ No

• If yes, please explain: _____

D. Child Mental Health History

Has your child been diagnosed with any of the following? (Please check all that apply)

Diagnosis	When Diagnosed	By Whom
<input type="checkbox"/> Alcohol Addiction or Abuse		
<input type="checkbox"/> Anorexia		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Attention Deficit-Hyperactivity Disorder (ADHD)		
<input type="checkbox"/> Autism Spectrum Disorder		
<input type="checkbox"/> Bipolar Disorder		
<input type="checkbox"/> Conduct Disorder		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Developmental Delay		
<input type="checkbox"/> Drug Addition or Abuse		
<input type="checkbox"/> Intellectual Disability		
<input type="checkbox"/> Learning Difficulties (reading, math, writing, spelling, etc.)		
<input type="checkbox"/> Obsessive Compulsive Disorder		
<input type="checkbox"/> Oppositional Defiant Disorder		
<input type="checkbox"/> Schizophrenia		
<input type="checkbox"/> School Failure (failing grades, dropout, etc.)		
<input type="checkbox"/> Speech or Language problem (articulation, stuttering, etc.)		
<input type="checkbox"/> Tic Disorder		
<input type="checkbox"/> Other (please specify): _____		

Has your child ever received psychological counseling? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

Has your child ever received speech, occupational, physical, vision, or other therapies? ☐ Yes ☐ No

• If yes, what services, by whom (professional/agency), and when: _____

Has your child ever participated in educational services from a private entity (i.e., private tutor)? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

Has your child ever participated in an early intervention program? ☐ Yes ☐ No

• If yes, by whom (professional/agency) and when: _____

To your knowledge, has your child (check all that apply):

Please check all that apply.	Please give details, dates, and/or age of onset
<input type="checkbox"/> Used or abused alcohol?	
<input type="checkbox"/> Used/abused drugs (prescription or illegal)	
<input type="checkbox"/> Injured him/herself on purpose	
<input type="checkbox"/> Attempted suicide	
<input type="checkbox"/> Talked about wanting to be dead	
<input type="checkbox"/> Threatened to hurt others	
<input type="checkbox"/> Been the victim of violence or aggression	
<input type="checkbox"/> Been the victim of bullying	
<input type="checkbox"/> Been abused (sexual, physical or emotional)	
<input type="checkbox"/> Harmed animals	

Additional Notes/Comments: _____

Please note any legal or criminal history: _____

III. FAMILY INFORMATION

A. Family Mental Health History

Does anyone in the child's family have a history of the following? (Please check all that apply)

Diagnosis	Father	Mother	Sibling	Grand-parent	Aunt/Uncle/Cousin
Alcohol Addiction or Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antisocial Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention Deficit-Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autism Spectrum Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Borderline Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addition or Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulties (reading, math, writing, spelling, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oppositional Defiant Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Failure (failing grades, dropout, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech or Language problem (articulation, stuttering, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tic Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Notes/Comments: _____

B. Family Stressors

Have any of the following things occurred in the family?

Event	Month, Year	Description
<input type="checkbox"/> Chronic illness		
<input type="checkbox"/> Death of loved one		
<input type="checkbox"/> Divorce or Separation		
<input type="checkbox"/> Financial Difficulties		
<input type="checkbox"/> Job Loss		
<input type="checkbox"/> Move		
<input type="checkbox"/> Other (please specify): _____		

IV. EDUCATIONAL HISTORY

What school does your child attend? _____

How does your child feel about school? _____

How motivated do you feel your child is to learn? _____

About how much time does your child spend on homework each night? _____

How much of a struggle is homework? ☐ Not a struggle ☐ Sometimes a struggle ☐ Often struggles

Has your child ever:

Please check all that apply.	Please give details, dates, and/or age of onset
<input type="checkbox"/> Repeated a grade or been held back?	
<input type="checkbox"/> Been expelled or suspended?	
<input type="checkbox"/> Missed more than 10 days of school in one school year?	
<input type="checkbox"/> Had an IEP (special education) or Section 504 Plan?	
<input type="checkbox"/> Had a significant decline in grades?	
<input type="checkbox"/> Been diagnosed with a learning disability?	
<input type="checkbox"/> Received extra support at school?	
<input type="checkbox"/> Been identified as gifted/talented?	
<input type="checkbox"/> Other (please specify): _____	

V. BEHAVIOR

A. Behavior in Infancy

During your child's first *few years of life*, were any of the following present to *significant* degree? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Did not enjoy cuddling | <input type="checkbox"/> Difficult nursing |
| <input type="checkbox"/> Was not easily calmed by being held or being stroked | <input type="checkbox"/> Poor eye contact |
| <input type="checkbox"/> Difficult to comfort | <input type="checkbox"/> Did not turn towards caregivers |
| <input type="checkbox"/> Colicky | <input type="checkbox"/> Did not respond to name |
| <input type="checkbox"/> Excessive irritability | <input type="checkbox"/> Did not respond to speech of caregivers |
| <input type="checkbox"/> Diminished sleep | <input type="checkbox"/> Fascination with certain objects |
| <input type="checkbox"/> Frequent head banging | <input type="checkbox"/> Constantly into everything |

Please describe all checked items: _____

B. Current Home Behavior

How would you describe your child's personality at home? _____

How does your child get along with brothers/sisters? _____

Who is primarily responsible for discipline at home? _____

What is the most effective way to deal with your child's behavior at home? (e.g., talking, time-out, grounding, etc.) _____

How does your child respond to discipline? _____

List any responsibilities your child has at home: _____

Indicate child's... Bed time ____:____PM Wake time ____:____AM Does child sleep well? ☐ Yes ☐ No

How much time does your child typically spend on electronics (computer, video games) each day? _____

Have any family members expressed concerns about your child's behavior? ☐ Yes ☐ No

• If yes, please explain: _____

E. Social Behavior:

Does your child get along well with other children in the neighborhood? ☐ Yes ☐ No

• If no, please explain: _____

Describe your child's peer relationships and choice of friends? (i.e., how many friends? What age/genders?) _____

Does your child tend to be: ☐ Shy ☐ Outgoing ☐ A Leader ☐ A Follower ☐ Other (please specify) _____



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:	
-----------------------------------	--	--	--	--	--	--	--	--	--	--	--	---------------	--