HeartLAND
COUNSELING CENTER, INC.

2320 Dean Street, Suite 102
St. Charles, IL 60175
P: 630.443.9100 F: 630.443.9101
www.heartlandcounseling.org

Name of Client: _____
First (preferred) MI Last

Date of Birth: _____ Sex: ☐ M ☐ F

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Hours: _____

Check here if you DO NOT want us to leave phone messages: ☐ Preferred phone for messages: _____

Email address (for appt. reminders): _____

Current Marital Status: ☐ Single ☐ Married Spouse's Name: _____

Race: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Native-American ☐ Other _____

Occupation: _____ Employer: _____

If Patient is a Minor (under the age of 18)

Parent/Guardian Name _____ Phone _____

Parent/Guardian Name _____ Phone _____

Party Responsible for billing _____

Address: _____

My signature below indicates that I have been informed of, and given the right to review and secure, a copy of your Services Agreement and the HIPPA Notice of Privacy Practices and that I authorize you to use and disclose my protected health information to carry out:

- *Treatment (including direct or indirect treatment by other professionals involved in my treatment)*
- *Obtaining payment from third party payers (e.g. my insurance company, Heartland's billing company)*
- *The day-to-day operation of your practice (e.g. Heartland's office staff and accountant)*

I understand I may revoke this consent, in writing, at any time.
I hereby authorize payment to Heartland Counseling Center, Inc. I understand that I am financially responsible for any charges not covered by my insurance. I authorize the release of any information relating to this claim. I understand that verification of insurance benefits is not a guarantee of payment. (parent/guardian must sign for minor)

Signature _____ **Date** _____

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Consent to Treat Adolescent

I, _____ am the parent or legal guardian of _____
(parent or guardian) (client)

_____ I am aware that limited information may be shared with me regarding the content of the session with my child. I understand that this is important for developing trust between therapist and client.

_____I am aware that my therapist is a mandatory reporter and any disclosure of child abuse will be reported to the appropriate child protective service authority. I understand that I will be informed of such reporting and have the opportunity to make the report personally.

_____ I am aware that I will be informed of any and all treatment plans and progress on a regular basis.

_____ I am willing to play an active role in my child's treatment or participate in my child's therapy session as deemed appropriate by my therapist.

_____ I am aware that I may end treatment at any time for any reason.

_____ I have been informed of the benefits and risks of treatment and I give this therapist permission to begin treatment.

I have read and understand the above statements or have had the chance to discuss any and all questions I have regarding these statements.

_____ _____
Signature of Parent/Guardian Date

I, the therapist, have discussed the above statements with the child's parent or guardian. There is no reason to believe that this person is not fully competent to give informed and willing consent to the child's treatment.

_____ _____
Signature of Therapist Date

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Office Policies & Procedures – Adolescents 12-18

Adolescent and Parent - Please initial on the lines, indicating you have read and agree to each policy.

x_____ x_____ MINORS & PARENTS: The law allows parents/ guardians of patients under 12 years of age to examine their child's treatment records. Parents of children between 12 and 18 cannot examine their child's records unless the child consents and unless the therapist finds that there are no compelling reasons for denying the access. Parents, including non-custodial parents are entitled to information concerning their child's current physical and mental condition, diagnosis, treatment needs, services provided, and services needed.

Since parental involvement is often crucial to successful treatment, in most cases, it is important for parents to have consent to review treatment records. The following is an agreement between the child patient and their therapist for such records to be review by their parents.

☐ I acknowledge that my parents are entitled to information concerning my treatment including current physical and mental condition, diagnosis, treatment needs, services provided, services needed, and any concerns with risk to myself or others.

Choose one:

☐ I give consent for all necessary treatment information to be discussed or released to my parent / guardian for the benefit of my therapy.

☐ I agree to allow *specific* information to be released to my parent or guardian; no information is to be released without my express consent.

☐ I do not agree to allow any information other than that which is legally required (current physical and mental condition, diagnosis, treatment needs, services provided, and services needed) to my parent or guardian.

Child printed name	Adolescent signature	Date

Patient Name: _____

Office Policies & Procedures – Adolescents 12-18

Adolescent and Parent - Please initial on the lines, indicating you have read and agree to each policy.

x_____ x_____ CONFIDENTIALITY: The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA and/or Illinois law.

There are some situations in which an authorization form is not needed to disclose information:

- A court order or subpoena for the release of information
- If your therapist has reasonable cause to believe that a child under 18 may be an abused or neglected child, the law requires that we file a report with the local office of the Department of Children and Family Services.
- If your therapist has reason to believe that an adult over the age of 60 living in a domestic situation has been abused or neglected in the preceding 12 months, the law requires that we file a report with the agency designated to receive such reports by the Department of Aging.
- If you have made a specific threat of violence against another or if your therapist believes that you present a clear, imminent risk of serious physical harm to another, we may be required to disclose information in order to take protective actions.
- If your therapist believes that you present a clear, imminent risk of serious physical or mental injury or death to yourself, we may be required to disclose information in order to take protective actions.

In any of the previous situations, your therapist will make every effort to fully discuss it with you before taking any action and will limit disclosure to what is necessary.

x_____ x_____ TELEPHONE & EMERGENCY PROCEDURES: To confirm or cancel your appointment, please leave a message on your therapist's voicemail or send an email directly to your therapist. Feel free to use our voicemail system to leave a message for your therapist.

- If you need to contact your therapist between sessions, please leave a message on your therapist's voicemail at (630) 443-9100 and your call will be returned as soon as possible.
- If you are having a medical or mental emergency call the 24-hour National Suicide Prevention Lifeline at (800) 273-8255, 911, or go to the nearest emergency room.
- Regularly requested calls and/or calls lasting more than 10 minutes will be billed proportionately, unfortunately your insurance company will not reimburse for phone calls.

Please take time to review Heartland Counseling Center Inc.'s HIPPA Notice Form Posted in the waiting room. Here you will find some of the above information in greater depth and detail.

Patient Name: _____

x_____ x_____ BILLING AND PAYMENT:

- Please feel free to call Dawn Zappitelli at extension 204 if you have questions about your payment or insurance reimbursement.
- We will bill your insurance company in an attempt to receive payment for all covered benefits. Please be aware that you are ultimately responsible for all charges should your insurance company decline payment.
- We will code all insurance claims according to documentation by your therapist. We will bill according to established guidelines in the DSM-V. If no diagnosis is present or your therapeutic needs fall under certain diagnostic categories, your insurance may deny payment. Please do not ask us to alter or change billing codes.
- Co-pays and self-pay fees will be collected at each visit.
- If you have a deductible that has not been met, we expect full payment at the time of service based on contracted rates with our insurance company.
- Outstanding balances older than 60 days will be charged a $25 delinquent account fee and be turned over to our collections agency. Non-payment will result in a report to the Credit Bureau.
- For accounts that reach a balance of $300, a payment plan will need to be determined between responsible party and therapist.
- Checks returned with insufficient funds will incur a $25 administrative fee.
- We accept Visa, MasterCard, Discover, debit card, cash, and personal checks.

If you would like to keep a credit card on file for recurring payments, we will need the following information:

Type of Card: ☐ Visa ☐ MasterCard ☐ Discover

Card Number: _____-_____-_____-_____

Expiration Date: _____

Card Holder Signature: _____ Date: ____/____/____

I authorize Heartland Counseling Center, Inc. to charge my credit card for professional services as follows: (check appropriate box or boxes)

☐ A recurring charge, for an amount not to exceed $_____, to be charged at the time of each visit.

☐ A recurring charge, for the exact amount of $_____, to be charged every _____ week(s) until the balance of my account is $0.00.

☐ To charge my credit card for the balance of fees not paid by my insurance company within 90 days.

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Patient Name: _____

x_____ x _____ CANCELLATION POLICIES & PROCEDURES: While we hope you attend every session, we understand that there are unforeseeable circumstances, which may prohibit your attending a scheduled session. In order to manage missed appointments, we adhere to the following policies.

- A minimum of 24 hours notice is required for rescheduling or canceling an appointment.
- Depending on your therapist's availability, you may be able to reschedule your appointment if your therapist has an appointment in the same week. If you take that appointment, the missed appointment fee will no be changed. Please understand that this is a courtesy and is determined by each individual therapist.
- You are responsible to pay for the missed appointment fees; they will not be billed to insurance or other third party payers.
- The fee for a missed appointment is $40.

I have read and understand these policies:

_____	_____	_____
Signature of Adolescent	Printed Name of Adolescent	Date

_____	_____	_____
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

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Consent for Release of Confidential Information via Text Messaging and/or E-mail

Name: _____ DOB: _____

I authorize Heartland Counseling Center, Inc. to communicate with me via:

_____Text messaging to this cell phone number: _____

_____E-mail messages to this email address: _____

I have been informed:

- That this is not a consent to provide treatment services via text or email.
- There are risks and benefits of electronic communications, and it is in my best interest and my responsibility to set a security lock on my phone and/or email account.
- It is possible that email or text may inadvertently be sent to the wrong address or phone number.
- My email and/or text messages to Heartland Counseling Center, Inc. may not be viewed immediately and are not a substitute for speaking with a therapist.
- If I have not received a response to my message within three business days, I should call Heartland Counseling Center, Inc. to speak with my therapist.
- Email and/or text messages that I send or receive may be viewed by others.
- Copies of email may exist even after the sender or the receiver has deleted his or her copy.
- I may be charged for text messages, at standard text messaging rates from my provider.
- **I should call 911 in an emergency, and not use email or text messaging to ask for help in a crisis.**

I authorize my therapist to release these types of messages (mark all that are authorized):

_____Information about appointments (reminders, updates, changes, cancellations, etc.)

_____E-mail attachments such as informational pamphlets, work sheets, self-help guides

_____Notification about events at Heartland Counseling Center, Inc. or in the community

_____Information regarding treatment progress

_____Other: _____

I understand that my records are protected under the Federal Confidentiality Regulation and the Mental Health and Developmental Disabilities Confidentiality Act of Illinois and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may (in writing) revoke this consent at any time except to the extent that disclosure was made prior to the time I revoked it. I further understand that disclosure included the right of the recipient to inspect and receive copies of the information to be disclosed.

This consent remains in effect as long as I am a client of Heartland Counseling Center, Inc., unless I revoke it. If I refuse to consent to this authorization, I will not receive electronic communications from Heartland Counseling Center, Inc.

Date	Signature of client (required if 12 years or older)	Printed Last Name
Date	Signature of Parent, Guardian or Legal Patient Representative	Printed Last Name and relationship
Date	Witness	Printed Last Name

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FOID Reporting

On July 9th 2013, Illinois passed HB 183 (Public Act 098-0063), also known as the Firearm Concealed and Carry Act. The Firearm Concealed and Carry Act expands the reporting requirements for healthcare facilities and physicians, clinical psychologists and qualified examiners to include any person that is: adjudicated mentally disabled person; voluntarily admitted to a psychiatric unit; determined to be a "clear and present danger"; and/or determined to be "developmentally disabled/intellectually disabled".

WHAT THIS MEANS FOR YOU:

- Our therapists are considered by the State of Illinois to be qualified examiners and are required to make reports on any clients who have been active since January 2014.
- We are required to make a report within 24 hours if a client is considered to be a clear and present danger to self or others.
- We are required to make a report within 7 days if a client is diagnosed as developmentally delayed/disabled or intellectually delayed/disabled or is an adjudicated mentally disabled person.

- **"Clear and Present Danger" means a person who:**
  - communicates a serious threat of physical violence against a reasonably identifiable victim or poses a clear and imminent risk of serious physical injury to himself, herself, or another person as determined by a physician, clinical psychologist, or qualified examiner; or
  - demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions, or other behavior, as determined by a physician, clinical psychologist, qualified examiner, school administrator, or law enforcement official. (FOID Act, Sec. 1.1)

- **"Developmentally disabled" means a person who has:**
  - a disability which is attributable to any other condition which results in impairment similar to that caused by an intellectual disability and which requires services similar to those required by intellectually disabled persons. The disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap. (FOID Act Sec. 1.1)

- **“Intellectually Disabled” means a person who has:**
  - significantly sub average general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years. (FOID Act Sec. 1.1)

- **"Adjudicated mentally disabled persons" means a person who:**
    - Presents a clear and present danger to himself, herself, or to others (must be reported with 24 hours)
    - Lacks the mental capacity to manage his or her own affairs or is adjudicated a disabled person as defined in Section 11a-2 of the Probate Act of 1975
    - Is not guilty in a criminal case by reason of insanity, mental disease or defect
    - Is guilty but mentally ill, as provided in Section 5-2-6 of the Unified Code of Corrections
    - Is incompetent to stand trial in a criminal case
    - Is not guilty by reason of lack of mental responsibility under Articles 50a and 72b of the Uniform Code of Military Justice, 10 U.S.C. 850a, 876b
    - Is a sexually violent person under subsection (f) of Section 5 of the Sexually Violent Persons Commitment Act
    - Has been found to be a sexually dangerous person under the Sexually Dangerous Persons Act
    - Is unfit to stand trial under the Juvenile Court Act of 1987
    - Is not guilty by reason of insanity under the Juvenile Court Act of 1987
    - Is subject to involuntary admission as an inpatient as defined in Section 1-119 of the Mental Health and Development Disabilities Code
    - Is subject to involuntary admission as an outpatient as defined in Section 1-119.1 of the Mental Health and Developmental Disabilities Code
    - Is subject to judicial admission as set forth in Section 4-500 of the Mental

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I have read and understand the above statements or have had the chance to discuss any and all questions I have regarding these statements.

_____ _____

Signature of Adult Client or Parent/Guardian Date

_____ _____

Signature of Adolescent Client (12+) Date

I, the therapist, have discussed the above statements with the client and/or the client's parent or guardian and answered all questions to the best of my knowledge.

_____ _____

Signature of Therapist Date

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Child & Adolescent Background Questionnaire

Date: _____
Name of person completing this form: _____
Relation to child: _____

Identifying Information

Child's name: _____ Gender: ☐ Male ☐ Female
Date of Birth: _____ Age: _____
Ethnicity/Race: _____
Is there anything about the child's cultural background that is important for the therapist to know? _____
_____

Marital Status of Parents or Legal Guardians:

☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never Married

Family Composition

Household Members: *Please list all adults and children living full-time or part-time in the home.*

Name	Age	Occupation	Relationship to Child

Does the child have any family members (parents, siblings, grandparents, uncles/aunts,) who have had mental health difficulties such as depression, bipolar, anxiety, substance abuse, etc? Or are there issues in family history that are important to explore in therapy? (please explain) _____
_____
_____

Child's Mental Health History

Has the child ever had an evaluation or treatment for behavior or emotional problems?
☐ No ☐ Yes… If yes, please list where it was provided, most recent place first.

1. Place of service/clinician: _____
Date: _____ Diagnosis given: _____
Type(s) of service: ☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication ☐ Group therapy
☐ Other (please explain) _____

2. Place of service/clinician: _____
Date: _____ Diagnosis given: _____
Type(s) of service: ☐ Evaluation only ☐ Individual therapy ☐ Family therapy ☐ Medication ☐ Group therapy
☐ Other (please explain) _____

Name: _____

Please check all that apply for the child:

- ☐ Stay at psychiatric hospital
- ☐ History of self-harm thoughts/actions
- ☐ Current self-harm thoughts/actions
- ☐ History of suicidal thoughts
- ☐ Past suicide attempt
- ☐ Current suicidal thoughts
- ☐ History of wanting to harm others
- ☐ Current thoughts of harm to others
- ☐ Taken medications for mental health

To the best of your knowledge, has the child ever been the victim the following abuses:

☐ Verbal ☐ Physical ☐ Sexual ☐ Neglect

Was the abuse reported to officials? _____

Comments: _____

_____

Has the child ever been traumatized by a past event such as a serious accident, been the victim of a crime, or involved in a natural disaster?

☐ No ☐ Yes… If yes, please explain _____

_____

_____

Has the child had a recent loss, or do you feel the child thinks or talks about a past loss too much? _____

_____

_____

Child's Developmental History

Did the child's birth mother have any of the following problems during her pregnancy with the child? *Please mark all that apply*

- ☐ Excessive Vomiting
- ☐ Anemia
- ☐ High or Low Blood Sugar
- ☐ Injury to Abdomen
- ☐ Stress /emotional problems
- ☐ High Blood Pressure
- ☐ Use of Cigarettes, Alcohol
- ☐ Use of Drugs
- ☐ Infection
- ☐ Bleeding
- ☐ Use of medication
- ☐ Other: _____

Did the child's birth mother have any of the following problems during her labor/delivery of the child?

- ☐ Premature Delivery
- ☐ Breach / Forceps Delivery
- ☐ Caesarean Delivery
- ☐ Infection at Delivery
- ☐ Yellow jaundice at birth
- ☐ Birth Injury or Defects
- ☐ Long Labor
- ☐ Medication during delivery
- ☐ Intensive care after birth
- ☐ "Blue Baby" / Lack of oxygen at birth
- ☐ Other: _____

What was the child's birth weight? _____lbs _____ounces

At what age did the child reach his/her developmental milestones?

Walked at (about)_____ months

Toilet trained by_____ months

Said first words at _____months

Said sentences (at least 2 words together _____months

Child's Medical History

Name, Address, and Telephone Number of Pediatrician or Family Doctor:

_____

Has the child had any of the following medical problems? *Please mark all that apply*

- ☐ Allergies
- ☐ Head Injury
- ☐ Loss of Consciousness
- ☐ Seizures
- ☐ Headaches
- ☐ Dizzy / Fainting
- ☐ High/Low Blood Sugar
- ☐ Vision Problems
- ☐ Trouble hearing
- ☐ High lead level
- ☐ Stomach/Intestine problem
- ☐ Heart Problem
- ☐ Frequent Pain
- ☐ Liver/Kidney
- ☐ Lung Problem/Asthma
- ☐ Joint Pain
- ☐ Chronic Pain
- ☐ Back/Neck Problems
- ☐ Other: _____

Please comment on any issues noted above: _____

_____

_____

_____

Name: _____

Does the child take any medicine every day? ☐No ☐ Yes Name/Dosage:_____
How many hours a night does the child typically sleep? _____ Nap? _____
Please describe any sleep concerns: _____

_____

_____

Would you say, given the child's height, he/she is: ☐ Underweight ☐ Just Right ☐Overweight
Has the child recently experienced: ☐ Weight Gain ☐ Weight Loss
Do you have concerns about the child's eating habits / preferences? ☐ No ☐ Yes
Do you have concerns about the child's exercise level? ☐ No ☐ Yes

Child's Substance Use: ☐ *Please check here if not applicable*

How many alcoholic drinks does the child have each week? _____
What does the child drink: ☐ Beer/Wine ☐ Mixed drinks ☐ Hard liquor
Does the child smoke any cigarettes, cigars, pipes, or use chewing tobacco? ☐ No ☐ Yes
Does the child use any other substances such as marijuana, heroin, inhalants or prescription drugs? ☐ No ☐ Yes
Has the child used any of these in the last 48 hours? ☐ No ☐ Yes
Has the child used any of these in the last 30 days? ☐ No ☐ Yes
Is there a family history of problems with drugs or alcohols? ☐ No ☐ Yes…If yes, please describe_____

_____

Has the child's tolerance increased over time (does the child drink or use more than previously)? ☐ No ☐ Yes

Child's School History

School currently attending: _____ Grade:_____
Has the child ever failed or been held back a grade? ☐ No ☐ Yes…Which one(s)? _____
Please describe the child's academic performance: _____

_____

Does the child receive special education services? ☐ No ☐ Yes… IEP Classification:_____
What grade did services begin?_____
Has the child ever been tested for learning or language problems? ☐ No ☐ Yes
If yes, where? _____ When? _____
Results? _____

Child's Employment History: ☐ *Please check here if not applicable*

Where does the child work? _____
What does the child do?_____
Concerns?_____
Has the child had trouble keeping a job? ☐ No ☐ Yes…If yes, please describe_____

_____

_____

Child's Legal History: ☐ *Please check here if not applicable*

Does the child have any current legal difficulties (traffic, civil, criminal)? ☐ No ☐ Yes, if yes, please describe:____

_____

_____

Has the child had any previous legal difficulties? ☐ No ☐ Yes…If yes, please describe_____

_____

Name: _____

Child's Social History:

Have there ever been any observed or reported concerns with social skills or development for the child?_____

_____

_____

How well does the child make / keep friends? _____

_____

_____

Please describe the child's leisure and recreation activities:

_____

_____

_____

Spiritual/Religious History:

How important are spiritual matters to the child's family?	☐ Not at all	☐ Little	☐ Moderate	☐ Very much
Is the child's family affiliated with a spiritual or religious group?	☐ No	☐ Yes (describe) _____		
Is the child currently being raised within an active spiritual or religious group?	☐ No	☐ Yes (describe) _____		
Would you or the child like to incorporate beliefs into counseling?	☐ No	☐ Yes (describe) _____		

Current Concerns:

Please check any items that currently concern you:

☐ Depressed mood	☐ Anxiety	☐ Anger	☐ Frequent sickness
☐ Irritability	☐ Muscle tension	☐ Mood Swings	☐ Frequent tiredness
☐ Feeling numb	☐ Difficulty breathing	☐ Impulsivity	☐ Poor concentration
☐ Appetite or weight change	☐ Racing heart	☐ Alcohol or drug use	☐ Auditory hallucination
☐ Change in energy level	☐ Panic attacks	☐ Restlessness	☐ Visual hallucination
☐ Relationship problems	☐ Avoidance of situations	☐ Distractibility	☐ Motor difficulties
☐ Hopelessness	☐ Obsessive thoughts	☐ Confusion	☐ Sexual issues
☐ Suicidal thoughts	☐ Compulsive behavior	☐ Sleep changes	☐ Nightmares
☐ Avoidance of people	☐ Fears		

☐ Other: _____

_____

How do these concerns interfere with the child's life?_____

_____

_____

What are the child's strengths?_____

_____

_____

What are the child's weaknesses?_____

_____

_____

What are the goals for therapy with the child? _____

_____

_____