Patient Information			
Patient's Name: (First, MI, Last)			Marital Status: Single/Mar./Div./Other
Street Address:			DOB: / /
City, State, Zip Code:			Male or Female
Home Phone:	Work Phone:	Cell Phone:	S.S.#:
Circle One: Employed: _____ Full Time Student Part Time Student			
Presenting Problem:		Medications:	
Whom may we Thank for referring you?			

Parent or Guardian Information for Children.		
Mother/Guardian's Name:	Work Phone:	Cell Phone:
Address (if different):		
Father / Guardian's Name:	Work Phone:	Cell Phone:
Address (if different):		

Insurance Information (Please Give Us Your Insurance Card To Copy)		
Name of Primary Insurance and Policy Holder:	Name of Employer:	DOB:
ID or Subscriber #:	Group #:	Deductible or Co-Pay:
Relationship to patient if not self:		
Name of Secondary Insurance and Policy Holder:	Name of Employer:	DOB:
ID or Subscriber #:	Group#:	
Relationship to patient if not self:		

In Case Of Emergency		
Name of relative or friend:	Relationship to Patient:	Home and/or Cell #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Glen Manor Counseling or insurance company to release any information to process my claims.

_____ _____

Patient/Guardian Signature Date

Glen Manor Counseling, Ltd.
INFORMED CONSENT

Thank you choosing Glen Manor Counseling, Ltd. Today's appointment will *take approximately 45 – 50 minutes. We realize that starting counseling is a* major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims/verify treatment or information necessary to collect payment, b) information you and/or you child or children report about physical or sexual abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) and as outlined in the HIPAA Notice of Privacy Practices. We only maintain clinical records and do not keep psychotherapy notes. If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community for those services. **Glen Manor Counseling, Ltd.** will follow those emergency services with standard counseling and support to the client or the client's family.

Signature(s):_____Date:_____

FINANCIAL/INSURANCE ISSUES: If you have no insurance benefits for mental health, we ask that you pay in full at each session. As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. If you have insurance, we ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds $300.00 we ask that you pay for services when rendered. We will charge $25.00 for any returned checks. After 60 days, any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fees/court costs charged to our office to collect the debt owed, collection fees are typically one third to one half of the amount owed. We ask that every client authorize payment of medical benefits directly to: **Glen Manor Counseling, Ltd.**

Lastly, if you need to cancel or reschedule an appointment, please give 24 hours notice. If your appointment time can't be filled a charge of $100.00 will be applied. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

Signature(s):_____Date:_____

Continued on next page……

Informed Consent continued from previous page.

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: _____

CLINIC: _____

ADDRESS: _____

PHONE: _____

There is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

Signature(s):_____Date:_____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

Signature(s):_____Date:_____

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that _____ maybe treated as a client by Glen Manor Counseling, Ltd.

Signature(s):_____Date:_____

Glen Manor Counseling, Ltd.
PATIENT RIGHTS

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

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

Right to inspect and copy your medical and billing records.
You have the right to inspect and obtain a copy of your information contained in our medical records. To request to access to your billing or health information, contact the office staff. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

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

Right to an accounting of disclosures.
You have the right to request an accounting of disclosures, if any, which is a list of certain disclosures such as child or elder abuse, disclosures related to suicidal or homicidal threats, disclosures to the U.S. Dept. of Health and Human Services to evaluate compliance.

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

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

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

Glen Manor Counseling, Ltd.
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CARFULLY.

Glen Manor Counseling, Ltd. has been and will always be totally committed to maintaining confidentiality. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

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

Uses and disclosures of your health information for the purpose of providing services: Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal law allows us to use and disclose your health information for the purposes.

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

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

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

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: 1) Information you and/or your child or children report about physical or sexual abuse: then by Illinois State Law, we are obligated to report this to the Department of Children and Family Services. 2) If you provide information that informs us that you are in danger of harming yourself or others. 3) Information to remind you of / or to reschedule appointments or treatment alternatives. 4) Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.