Gale Nienhuis MSW/LCSW
Heartsource Therapy P.C.
33. E Colorado, Frankfort, IL 60423
Ph:708-837-3319 Fx: 815-469-6481
Email: heartsourcetherapy77@gmail.com

New Client Intake

Thank you for choosing our office. Please fill out the attached forms completely. If you have any questions, your therapist will be happy to provide further explanation.

Date ______________________________

Client Name ____ Age______ Date of Birth_____________________

Address____City_____________________State____Zip__________

Home Number___________________________ ___ Can we leave a message? Yes No

Work Number______________________________ Can we leave a message? Yes No

Cell phone _________________________________ Can we leave a message? Yes No

E-mail address____

Marital status: ____Single ____Married/Cohabitating ____Separated _____Divorced ____Widowed

Date__________ Date________ Date_______ Date________

Race_________________ Ethnicity_____________________ Religion____________________________

Emergency Contact____**Relationship to client** _______________________

Emergency contact: Home number :___________________Work:________________Cellphone number:_________________

Family/Household Members	Date of Birth	Relationship	Currently living with you? Yes / No

How did you find out about our services? ____

The following are a list of questions that will help me to better understand why you are entering treatment at this time. Any topics you are uncomfortable disclosing on this form may be reserved for our discussion during our initial assessment session.

Describe why you are seeking counseling____

____

____

____

Please check any of the below listed symptoms that you are experiencing:

___sadness / tearfulness	___fatigue	___low energy	___sleep problems
___appetite/ weight change	___irritability	___feelings of guilt	___memory problems
___poor concentration	___excessive worry	___anger	___loss of pleasure
___anxiety	___panic attacks	___hopelessness	___suicidal thoughts
___hearing or seeing things that aren't there		___paranoia	___impulsiveness
___mood swings	___excessive energy	___racing thoughts	___restlessness
___binge eating	___purging food	___obsessions or compulsions	
___phobias	___sexual dysfunction	___violent behavior	

Do you use drugs, alcohol, nicotine or abuse prescription medications?
____

If yes, please describe your past and present use. Please list what substances, how much and how often.
____

____

Do you have any behaviors that you feel are of concern? (Gambling, risk taking, etc)

____

List any medical problems ____

____

List any medications you are currently taking: Medication /Dose/how often?

____

____

____

Have you seen a psychiatrist, psychologist or therapist in the past? If yes, who did you see and for what reason.

____

Primary Care Physician____Phone number_____________________

Psychiatrist ____Phone number______________________

Have you ever been hospitalized for psychiatric reasons?____

Have you ever received treatment for an addiction? (Alcohol, drugs, etc.)_______________________________________

Do you or have you ever attended a self help group? (AA, Al-Anon, CoDa, NA, GA, etc.)___________________________

Do you have any legal problems or involvement with Law Enforcement? ____

Any current legal cases pending?____

Current employement____

Have you ever served in the military?   ____

Are you dealing with any stressors that are currently impacting your life?_______________________________________

____

Family History

Has anyone in your family had a problem with?

_______alcohol abuse   _____drug abuse   _____violence   _____gambling

_______prescription drug abuse   _____mental illness

Is there any family history you feel is important to disclose?

____

____

____

Any additional information that would be pertinent to the counseling process_________________________________

____

____

Gale Nienhuis MSW/LCSW
Heartsource Therapy P.C.
33 E. Colorado, Frankfort, IL 60423
Ph: 708-837-3319 Fx: 815-469-6481
Email: heartsourcetherapy77@gmail.com

Insurance Information

It is the client's responsibility to contact their insurance company to verify coverage and to secure any preauthorization of services. Insurance companies will be billed as a courtesy to our clients. As noted in the financial policy no show appointments and late cancellations may incur a fee that is not reimbursed by insurance companies or employee assistance programs. Please note many insurance companies and employee assistance programs have a time limit in which to file claims. Be sure to notify your therapist immediately of any changes insurance coverage as we are unable to resubmit claims due to inaccurate insurance information.

Primary Insurance

Client Name____ Social Security Number__________________

Insured's Name____ Social Security Number__________________

Insured's date of birth___________________________ Relationship to client: Self Spouse Child Other

Insured's Address____________________________________City________________State_______Zip____________

Insurance Company____

Identification Number___________________________________Group Number_______________________________

Employer____Authorization Number__________________________

Secondary Insurance

Insured's Name____ Social Security Number__________________

Insured's date of birth___________________________ Relationship to client: Self Spouse Child Other

Insured's Address____________________________________City________________State_______Zip____________

Insurance Company____

Identification Number___________________________________Group Number_______________________________

Employer____Authorization Number__________________________

I acknowledge I have received the Financial Policy. (See separate Financial Policy) I give permission to Gale Nienhuis and the billing company to release information for the purpose of submitting claims to my insurance company or employee assistance program for payment of benefits for services received. I further agree to assign benefit payments directly to Gale Nienhuis to be applied to the balance on my account. I agree to pay all deductibles, co-payments and co-insurance. Payments are due at time of service and can be made in the form of cash, check or credit card.

____

Client or Parent/Guardian Signature Date

Gale Nienhuis MSW/LCSW
Heartsourcetherapy P.C.
33 E. Colorado, Frankfort, IL 60423
Ph: 708-837-3319 Fx: 815-469-6481
Email: Heartsourcetherapy77@gmail.com

Client Rights and Informed Consent

Thank you for choosing to enter treatment. Counseling is a process in which you will explore your thoughts, feelings, beliefs, values and behaviors in order to more effectively cope with problems of daily life and to deal with inner conflicts. You are expected to play an active role in your treatment, working jointly to outline your treatment goals and to assess your progress. Progress in your goals will require not only your regular participation in therapy sessions but also on the work you do between sessions. Many times this can include questionnaires, assessments and homework assignments. Although it is common to feel some relief after an initial session or two, therapy can involve discussion of unpleasant aspects of your life and uncomfortable feelings. This is a normal part of the therapeutic process. Ultimately therapy can lead to better relationships, solutions to specific problems, and significant reduction in feelings of distress.

Since the counseling relationship is crucial to the counseling process, please feel free to discuss any questions or concerns with me at anytime. In the event you decide to discontinue counseling, it is best that we discuss this and plan for a final session to discuss progress and possible referrals. If I believe I will cause an extended interruption in therapy, a short or longer term referral to another therapist will be made.

Understand that there are limits to our relationship mandated by professional ethics. Contact outside of our counseling relationship (employment, doing business, socializing, education, etc.) is discouraged.

Professional Fees

Initial Assessment: $180.00, Individual Therapy: (45 minutes) $130.00, Individual therapy (60 minutes): $150.00, Couple/Family Therapy: $ 150.00. (In certain circumstances, the therapist reserves the right to adjust session length and fees as necessary.)

Billing and Payments

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage. As a courtesy, your therapist or billing service will file claims with your insurance company. (Please note, each therapist is an independent practitioner and thus participates in varied insurance plans and employee assistance programs.) Copayments are due at the time services are rendered. (See Financial Policy for additional information.)

Confidentiality

With some specific limitations, your verbal communication and clinical records are confidential. Exceptions include:

- When you give me written permission to release information as outlined in the HIPPA Notice of Privacy Practice;
- If I believe that you are in danger of harming yourself or others, I may be required to take protective actions. (For example, actions may include notifying the potential victim, contacting family or police, or seeking hospitalization for the client.);
- As a mandated reporter, I am required by law to report the following:
    - Physical, sexual abuse, and neglect of a minor,
    - Elder abuse
    - The Illinois Concealed Carry Law requires Illinois clinicians to report those they believe pose a “clear and present danger” to themselves or others to the Illinois Firearms Owner Identification (FOID) Mental Health Reporting System.
- On rare occasions, courts might subpoena records or require that I testify in court;

- For the purpose of clinical consultation and supervision;
- In the event I need to retain a collection agency to pursue unpaid fees;
- For the purpose of securing insurance authorizations of care, care management or insurance billing;
- If you are a member of the armed forces, information about you may be released as required by military command authorities.

Record keeping

All therapists at Frankfort Counseling Associates are independent practitioners and maintain their own records and process their own claims. Therapists do not share written documentation with each other. As such clients may be required to complete forms if they are seeing more than one therapist at this location. If you have any questions about records or your claims/payments contact your therapist.

Appointments

Sessions can be scheduled by calling (708) 837 -3319. Sessions are generally held on a weekly basis, although the frequency of sessions will be determined when we discuss goals and personal needs. Regular attendance is critical to achieve the optimum benefit from counseling. If you must cancel an appointment, 24-hour notice is required to avoid any cancellation fee.

Emergency Situations

In the event of a crisis, you may attempt to contact me at (708) 837 -3319. Please keep in mind that your call may not be answered immediately, and I will return your call as soon as possible. If an emergency situation arises, for which you or your family feels urgent attention is necessary, call 911 or go to your nearest hospital emergency room.

Telephone Calls

If you have an issue and have to talk to me prior to our scheduled appointment, you may call me if a short telephone call (less than 10 minutes) would be helpful. If more time is needed, it is best to schedule an extra appointment. If that is unworkable, we can make a telephone appointment. I will charge my normal rate and applicable payment, co-payment and/or deductible would apply.

If you have any questions regarding the above office procedures, please feel free to discuss them at any time.

Gale Nienhuis, MSW/LCSW
Heartsource Therapy P.C.
33 E. Colorado, Frankfort, IL 60423
Ph: 708-837-3319 Fx: 815-469-6481
Email: heartsourcetherapy77@gmail.com

Financial Policy

Insurance Services
Each therapist is an independent practioner and thus participates in varied insurance plans and employee assistance programs. As a courtesy, I or my billing service will file claims with your insurance company; however it is ultimately your responsibility for the full and timely payment of your account. I or my billing service will attempt to verify insurance coverage and benefits. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment. Because many insurance companies have a time limitation on which claims can be filed on your behalf, it is important that we have current insurance information. If you are using an EAP service or have any changes in your insurance coverage, please provide that information to me at your next session. Please be aware that certain diagnoses and/or services may not be covered or may be considered õnot medically necessaryö by your health plan. You are responsible for payment of these services. Please also be aware that some health plans limit annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. I will provide care based on the clientøs needs not a clientøs insurance coverage.

Fees*
Initial Assessment: $180.00, Individual Therapy (45 minutes) $130.00, Individual therapy (60 minutes) $150.00, Couple/Family Therapy $150.00. (In certain circumstances, the therapist reserves the right to adjust session length and fees as necessary.)

On occasion, outside parties may request written documentation of counseling, (attorneys, doctors, disability insurance companies, etc.). With your written permission your therapist can prepare reports for an additional fee. (Please note these fees are not reimbursable by insurance.)

For clients with <u>no insurance coverage</u>, a sliding fee may be available. Please consult your therapist for these fees.

Copayments
All copayments are due at the time services are rendered.

Cancellation Policy
Regular attendance at your scheduled therapy sessions is integral to helping you to achieve your therapy goals. To make the most of your session, we make every effort to stay on time for all scheduled appointments. Due to the length of time provided for each session, it is critical that you arrive on time for your appointments. If you are more that 15 minutes late, we may have no choice but to reschedule your appointment, and you will be responsible for the fees of a no show. In order to avoid paying no show fees, we require at least twenty-four (24) hours notice for all cancellations. Cancellation messages for your therapist can be left at (708) 837 -3319. *Please note insurance companies cannot pay for a missed appointment or late cancellation.* Therefore you will be responsible for the $50.00 fee for the first no show (missed appointment) or late cancellation. In the event of additional missed appointments or late cancellations, you may be responsible for the entire fee of $130-150.00. We make every effort to have sufficient appointment times available for all our clients. Thus, clients who have repeated no show appointments and/or late cancellations may result in being referred back to your insurance company for reassignment to another provider.

Past Due Accounts
If your account becomes past due, we will make every effort to work with you to resolve this debt. However, unpaid accounts past 90 days will be charged a 1% per month interest charge.

NSF
If a check is returned for insufficient funds, account closed or payment is stopped, your account will be charged a $35.00 fee. In the event this happens, we will need to discuss future payment options.

*Fees are subject to change.

Gale Nienhuis MSW/LCSW
Heartsource Therapy P.C.
33. E. Colorado, Frankfort, IL 60423
Ph: 708-837-3319 Fx: 815-469-6481
Email: heartsourcetherapy77@gmail.com

Consent for treatment and confirmation of receipt of Client Rights, and HIPPA /Privacy Notice

I consent to treatment and have reviewed the Client Rights. I give permission for the emergency contact person to be called in the event of an emergency.

____ ____

Client Signature Date

____ ____

Parent/Guardian Signature Date

I acknowledge that I have received and have been given opportunity to review a copy of HIPPA/Notice of Privacy Practices. I understand that if I have any question regarding my privacy rights, I can contact my therapist, ________

____ ____

Client Signature Date

____ ____

Parent/Guardian Signature Date

I give my consent to inform my physician that I have begun therapy.

Physician Name______________________________________ Phone number________________________________

Address____

____ ____

Client Signature Date

____ ____

Parent/Guardian Signature Date

Gale Nienhuis, MSW/LCSW
Heartsource Therapy P.C.
33. E. Colorado, Frankfort, IL 60423
Ph: 708-837-3319 Fx: 815-469-6481
Email: heartsourcetherapy77@gmail.com

Optional Credit / Debit Card Payment Consent Form

As a courtesy we will keep your credit card information on file for outstanding charges. You may revoke this optional agreement at any time.

Patient Name ____ ______________________________
Last *First*

Name on card if different ____

I authorize ______________________________to charge my card for professional services as follows:

Initial

_______ To charge my card for the balance of fees including deductibles, copayments or co insurance amounts.

Not to exceed $ ____________ per visit.

Type of card: ☐ Visa ☐ Master card ☐ Discover ☐ American Express

Card Number: _____________-____________-___________-___________

Expiration Date: _____________/___________

CVV Number: ___________ (3 digit # on back of card or 4 digit # on front of card for American Express)

Zip Code of Billing Address ___________________

A receipt for payment can be issued to you via email or text to your cell phone

Card Holder Email Address: ____

Card Holder Cell Phone Number: (_________) __________________________

Card Holder Signature: ____ Date: ____________________

Gale Nienhuis, MSW/LCSW

Heartsource Therapy P.C.

33. E. Colorado, Frankfort, IL 60423

Ph: 708-837-3319 Fx: 815-469-6481

Email: heartsourcetherapy77@gmail.com

NOTICE OF PRIVACY PRACTICES

As your therapist, I am required by law to maintain the privacy of clients Protected Health Information (PHI) and to provide clients, with this NOTICE OF PRIVACY PRACTICES that describes how I may use and disclose PHI and your rights to access and control your PHI. PHI includes all individually identifiable health information transmitted or maintained by a therapist, regardless of form (oral, written or electronic). Your protected health information is covered by the HIPAA Privacy Rule and applies to a health care provider, health plan or health care clearinghouse that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future. I am required by law to protect medical information about you. As your therapist, I reserve the right to change provisions of the Notice and make new provisions effective for all PHI I maintain.

HITECH Amendments

Under HITECH, I am required to notify clients whose PHI has been breached. Notification must occur by first class mail within 60 days of the event. A breach occurs when an unauthorized use or disclosure that compromises privacy or security of PHI poses a significant risk for financial, reputational, or other harm to the individual. This notice must:

(1) Contain a brief description of what happened, including the date of the breach and the date of the discovery;

(2) The steps the individual should take to protect themselves from potential harm resulting from the breach;

(3) A brief description of what I am doing to investigate the breach, mitigate losses, and to protect against further breaches.

Cash Patients/Clients

HITECH states that if a patient pays in full for their services out of pocket, they can demand that the information regarding the service not be disclosed to the patient's third party payer/insurance company since no claim is being made against the third party payer/insurance company.

How I May Use Your Protected Health Information

The following describes the ways I may use and disclose health information that identifies your ("Health Information"). Except for the purposes described below, I will use and disclose Health Information only with your written permission. You may revoke such permission at any time by notifying me in writing.

For Treatment

I may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, with your permission, I may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who provide you with medical care.

I may share protected Health Information in the following circumstances without your permission:

- If I believe that you are in danger of harming yourself or others and I may be required to take protective actions. (For example, actions may include notifying the potential victim, contacting family or police, or seeking hospitalization for the patient.)
- As a mandated reporter, I am required by law to report the following:
    - Physical, sexual abuse, and neglect of a minor,
    - Elder abuse
    - The Illinois Concealed Carry Law requires Illinois clinicians to report those they believe pose a "clear and present danger" to themselves or others to the Illinois Firearms Owner Identification (FOID) Mental Health Reporting System. On rare occasions, courts might subpoena records, require that I testify in court or comply with a court-ordered warrant;
    - For the purpose of clinical consultation and supervision;
    - In the event I need to retain a collection agency to pursue unpaid fees;
    - For the purpose of securing insurance authorizations of care, care management or insurance billing;
    - If you are a member of armed forces, information about you may be released as required by military command authorities.

Payment

I may use and disclose Health Information so that I or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may give your health plan information about you so that they will pay for your treatment.

Health Care Operations I may use and disclose Health Information for health care operations purposes. These minimum disclosures are necessary to make sure that all of our clients receive quality care and to operate and manage our business. I also may share the minimum necessary information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services I may use and disclose Health Information to contact you to remind you that you have an appointment with us. I also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you, individuals Involved in your care or those involved with payment for your care.

Research

Under certain circumstances, I may use and disclose Health Information for research. For example, a research project may involve comparing the health of clients who received one treatment to those who received another, for the same condition. Before I use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, I may permit researchers to look at records to help them identify clients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Business Associates

I may enter into contracts with entities known as Business Associates that provide services to or perform functions on our behalf. I may disclose protected health information to Business Associates once they have agreed in writing to safeguard PHI. For example, I may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to safeguard protected health information.

Your Rights

Right to Inspect and Copy

In most cases, you have the right to inspect and copy the PHI I maintain about you. If you request copies, I may charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing. In some circumstances, I may deny your request to inspect and copy your health information if it is believed, in my professional judgment, that the disclosure would jeopardize your safety or that of others involved.

Right to Amend

If you believe that information within your records is incorrect or if important information is missing, you have the right to request that I correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, I may deny your request to amend your health information. If I deny your request, you may file a statement of disagreement with me for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures

You have the right to receive an accounting of certain disclosures of your PHI. The accounting will not include disclosures that are made, for purposes of treatment, payment or health care operations; to you; pursuant to your authorization; to your friends or family in your presence or because of an emergency; for national security purposes; or incidental to otherwise permissible disclosures. Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions

You may request a restriction on the disclosure of information about you for your treatment, payment or health care operations. Your request must be in writing to me. Your request must tell me what information you want to limit, whether you want to limit its use, disclosure or both, and to whom you want the limit to apply. For example you could ask that I not use or disclose information to a certain person about services you've received. I do not have to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide your emergency treatment or as otherwise required by law.

Right to Request Confidential Communications

You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to me. I am required to accommodate reasonable requests. For example, you may ask that I contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach

You have the right to be notified in the event that I (or one of my Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice

If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request.

Our Legal Responsibilities
I am required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information. I may change our policies at any time and reserve the right to make the change effective for all protective health information that I maintain. In the event that I make a material change in our policies, I will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.
If you have any questions or complaints, please contact: Gale Nienhuis, 33 E. Colorado Ave, Frankfort IL 60423, (708) 837-3319.
If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact the person listed above. You may also submit your complaint directly to the Department of Health and Human Services –Region V, Office for Civil Rights, U.S. Department of Health and Human Services, and 233 N. Michigan Ave., Suite 240, Chicago, IL 60601.

Revised 6/14