## LIFEWORK COUNSELING INFORMATION FORM

**Demographic Information** (Please print clearly)

Client name:_______________________________________________ Date:__________________

Date of birth:_____________________Age:_____ Social Security #:_________________________

Race:________________ Sex:__________________Religion:______________________________

Do you attend church/place of worship currently?____ Name:_______________________________

Parent's name(s), if client is a minor: __________________________________________________

Address:____________________________City/State/Zip:_________________________________

May we mail to this address? ____YES ____NO

Home phone:_____________________ Cell_____________________ Work___________________

Email address:_________________________ May we contact you via email? _______

May we contact you and leave a message by phone? (Authorize by placing a check next to source)

___Home ___Cell ___Work

**Marital/Family information**

Marital Status: ( )Single ( ) Engaged ( )Married ( )Remarried ( )Separated ( )Divorced ( )Widowed ( )Living with Partner

Spouse's name:________________________ Date of birth:______________________

How long have you been married? _________ Do you have children?______________

| Name | Age | Currently living with you? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Employment Information**

Place of Employment:________________________________________________________

( )Full time ( )Part time

Occupation:______________________________ How long have you worked here?_____________

Education (List highest level of education attained/degree):

______________________________________________________________________

**Briefly state your reasons for seeking counseling at this time**______________________________

________________________________________________________________________________

________________________________________________________________________________

**Problem Checklist (Please check any of the following that may apply)**

**Checklist #1**

- anxiety, tension, nervousness
- heart palpitations or pounding
- shortness of breath or rapid breathing
- high blood pressure/hypertension
- frequent upset stomach/indigestion/nausea
- muscle tension/spasticity/cramps
- coldness or numbness in fingers
- stiffness/aching burning sensation in joints
- dizziness or fainting spells
- frequent or severe headaches
- memory problems
- inability to concentrate
- crying spells
- frequent wakening/early wakening
- problems falling asleep
- excessive caffeine use
- excessive alcohol use
- excessive medication use
- drug use
- sexual functioning problem
- infertility
- hormonal imbalances(Menopause, PMS)
- pregnancy
- lack of appetite
- diarrhea/constipation
- urinary problems
- chronic pain
- chronic illness

**Checklist #2**

- loneliness
- bereavement
- fears and worries
- despair
- guilt
- shame
- unhappiness
- confusion
- troublesome dreams
- loss of faith in others
- loss of faith in God
- loss of meaning
- temper
- self-control
- criminal behavior
- gambling
- pornography/cybersex
- internet relationships
- decision making
- ambition
- assertiveness
- shyness
- dating
- friends
- education
- adoption
- eating disorder
- physical abuse
- sexual abuse
- sexual concerns
- homosexuality
- gender identity
- sexual response
- premarital concerns
- infidelity of self
- infidelity of partner
- couple problems
- parenting
- loss of love
- separation/divorce
- legal matters
- finances
- insecurity
- inferiority
- self-doubt
- self-concept

**Insurance Information**
If you are covered by insurance you will need to provide a copy of your insurance card(front and back) to your counselor at your first visit. Please fill out the information below, including secondary insurance information if applicable.

**Primary Insurance**
Insured name (as it appears on the card):_______________________________________________
Insured address if it is different from the client:__________________________________________
City_______________________________ State_____________ Zip_________________________
Relationship to the client:_____________________________________________________________
Insured date of birth:_____________________Insured social security #:______________________
Insurance Company:_______________________________________________________________
Insured ID#________________________________ Insured Group #_________________________
Employer name:_________________________Insurance telephone #s (back of card)___________
Deductible amount: $_____________________ Co-pay amount: $________________________

**Secondary Insurance**
Insured name (as it appears on the card):_______________________________________________
Insured address if it is different from the client:__________________________________________
City_______________________________ State_____________ Zip_________________________
Relationship to the client:_____________________________________________________________
Insured date of birth:_____________________Insured social security #:______________________
Insurance Company:_______________________________________________________________
Insured ID#_____________________________ Insured Group #_________________________
Employer name:_________________________Insurance telephone #s (back of card)___________
Deductible amount: $_____________________ Co-pay amount: $________________________

**Medical Information**

Primary Physician____________________________________ Phone_______________________
Psychiatrist__________________________________________ Phone_______________________
Currently taking medication?_________ (List medications and dosages below)
Medication Dosage
List any significant health problems

___________________________________________________________________________________

___________________________________________________________________________________

**Counseling Information**

How did you hear about LifeWork? ______________________________________________________
Who may we thank for referring you? ___________________________________________________
What type of counseling are you seeking? ( )Individual ( ) Couple ( )Family
Briefly state your reasons for seeking counseling at this time:______________________________

___________________________________________________________________________________
Have you ever been to counseling before? ___YES ___NO
If YES, when and with whom?__________________________________________________________
Give a brief description of treatment

___________________________________________________________________________________

**Emergency Contact Information**

Emergency Contact____________________Relationship_____________Phone Number___________

# INFORMED CONSENT

## CONFIDENTIALITY STATEMENT

All information shared in this treatment is confidential except in circumstances governed by law. If you would like your LifeWork counselor/clinician to confer with another healthcare professional and/or other professional related to your treatment at LifeWork Counseling, you will need to sign a "Release of Information" form. This permission form can be revoked by you at any time. During the period of informed consent, both parties agree to take all reasonable measures to ensure confidentiality with any communication in written form, by phone and/or via Internet.

## FINANCIAL AGREEMENT

Fees are payable at the time of service. Your fee per 50 minute session is $130.00. Fees are subject to change every six months. Your regular fee will be charged for any additional professional services at your request, such as phone contacts over 5 minutes, consults with other professionals, at a rate of $30.00 per 15 minutes. LifeWork Counseling accepts the following forms of payment: cash, check, cashiers check, Visa, Mastercard, American Express, and Discover. If you would prefer LifeWork Counseling to bill your credit card, please fill out the "Pre-Authorized Healthcare Form" enclosed.

## FINANCIAL POLICY

If you have insurance that provides coverage for this provider and type of treatment you will be receiving, LifeWork Counseling will assist you in processing your claim form. However, you are responsible for full payment of services not covered by your insurance company. Outstanding balances over 30 days will be charged an additional 5%. There will be a $15.00 charge for returned checks.

## NO-SHOW AND CANCELLATION POLICY

Your appointment is reserved time made at your request. A 24 hour notice is required for cancellation to avoid being charged a late cancellation fee of $100.00.

## STATEMENT OF UNDERSTANDING

I have read and agree to the terms of informed consent.

| ______________________________ | ______________________________ |
|---|---|
| Client | Date |
| ______________________________ | ______________________________ |
| Parent or Guardian if client is a minor | Date |
| ______________________________ | ______________________________ |
| Provider | Date |

# LIFEWORK COUNSELING CENTER
# 3500 SPRING ROAD, OAK BROOK, IL 60523, 630-655-0404

## ILLINOIS NOTICE FORM

**Notice of Mental Health Provider's Policies and Practices to Protect the Privacy of Your Mental Health**

**THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### I. Uses and Disclosures for Treatment, Payment and health Care Operations

I may use or disclose your Protected Health Information (PHI), for treatment, payment,and health care purposes, with your written authorization. To help clarify these terms, please read the following definitions:

- "PHI" refers to information in your health record that can identify you.
- "Treatment", "Payment", and "Health Care Operations"
  •Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. For example, consulting with your physician or your other mental health care provider.
  •Payment is when I obtain reimbursement for your healthcare. For example, if you elect to use your health insurance, I will disclose your PHI to our health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
  •Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within LifeWork Counseling, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of LifeWork Counseling, such as releasing, transferring, or providing access to information about you to other parties, or mental health provider within LifeWork Counseling.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

### II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or healthcare operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session which I have kept separate from the rest of your record. These notes are given a higher level of protection than PHI.

You may revoke all such authorizations (PHI and Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage. Law provides the insurer the right to contest the claim under the policy.

### III. Uses and Disclosures without Authorization

I may use or disclose your PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe a child known to me in my professional capacity may be an abused child or neglected child, I must report this belief to the appropriate authorities.
- **Adult and Domestic Abuse:** If I have reason to believe that an individual (who is protected by state law) has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.
- **Health Oversight Activities:** I may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure or disciplinary action.
- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information by any party about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release such information without a court order. I can release the information directly to you on your request. Information about all other psychological services is also privileged and cannot be released without your authorization or a court order. The privilege does not apply when your are being evaluated for a third party or where the evaluation is court ordered. You must be informed in advance if this is the case.
- **Serious threat to Health or Safety:** If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.
- **Worker's Compensation:** I may disclose protected information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law, that provide benefits for work-related injuries or illness without regard to fault.

## IV. **Patient’s Rights and the Mental Health Provider**

Patient’s Rights:

- ➡ Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- ➡ Right to Receive Confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communication of PHI by alternative means and at alternative locations. (Example: you may request that a family member not know you are seeing me. Or you may have your bill sent to another address.)
- ➡ Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about your for as long as the PHI is maintained in the record and Psychotherapy Notes. On your request, I will discuss with you the details of the request for access process.
- ➡ Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- ➡ Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- ➡ Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Mental Health Provider’s Duties:

- ➡ I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- ➡ I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- ➡ If I revise my policies and procedures, I will provide a written notice regarding my changes and mail them to you.

## V. **Questions and Complaints**

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Donald J. Olund, MA, Licensed Clinical Professional Counselor and Privacy Officer for LifeWork Counseling at (630) 655-0404.

If you believe your privacy rights have been violated and wish to file a complaint with me/my office, you may send your written complaint to Donald J. Olund, MA, LifeWork Counseling, 3500 Spring Road, Oak Brook, IL 60523.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. the person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

## VI. **Effective Date, Restrictions, and Changes to Privacy Policy**

This notice will go into effect on October 1, 2008.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing by mail.

**I have provided my client with a copy of the above Notice of Mental Health Provider’s Policies and Practices to Protect the Privacy of my Health Information.**

_____________________________________________________ ________________________________

Signature of Mental Health Provider Date

**I have read and received a copy of the above Notice of Mental Health Provider’s Policies and Practices to Protect the Privacy of my Health Information**

_____________________________________________________ ________________________________

Signature of recipient age 12 or older Date

_____________________________________________________ ________________________________

(Parent or Guardian of minor or legally disabled recipient) Date

If the signature is not the Recipient’s, indicate the legal relationship to the recipient: __________________________

_____________________________________________________ ________________________________

(Witness) Date