

# Hope Enrichment Center, PC

7300 W. College Dr., Suite 203  
Palos Heights, IL 60463  
(708) 448-7848

**WELCOME** to the Hope Enrichment Center. Please complete the following 5 sections of information prior to your first appointment. This will help us to better serve you! As you answer the questions, if you have any questions or concerns, please feel free to ask your therapist.

**Date:** \_\_\_\_\_ ***Today I am here to see:***

Carrie Ann Carr, LCPC     Amy Coots-Smith, LCPC     Erica Sidenstick, LCSW     Carolyn Necas, LCPC

Dr. Reid Schwartz, PhD     Jamie Gilmartin, LCPC     Amanda Jenkins, LCPC     Stephanie Herrera, LPC

Sandy Murray, LCSW     Cheryl Kokaska, MA, LCPC     Other: \_\_\_\_\_

## SECTION 1 – Contact information

<b>CLIENT NAME</b>	<b>DATE OF BIRTH</b> <span style="float: right;">Age</span>
<b>ADDRESS</b>	<b>CITY</b> <span style="float: right;"><b>ZIP</b></span>
<b>PREFERRED PHONE #</b> TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> OTHER	<b>MAY WE LEAVE A MESSAGE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>OTHER PHONE #</b> TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> OTHER	<b>MAY WE LEAVE A MESSAGE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>GENDER :</b>	
<b>MARITAL STATUS</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOW	<b>EMPLOYER/SCHOOL NAME</b>
<b>EMAIL ADDRESS</b>	<b>OCCUPATION/JOB POSITION</b>
<b>EMERGENCY CONTACT &amp; PHONE:</b>	<b>EMERGENCY CONTACT RELATIONSHIP TO CLIENT:</b>
<b>RELEASE OF INFORMATION SIGNED FOR EMERGENCY CONTACT:</b> YES    NO	<b>MAY WE SEND MAIL TO YOUR HOME:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <i>(All mail comes from "HEC" discreetly)</i>

*If the client is a minor, please complete the following information.*

<b>WHO DOES MINOR RESIDE WITH?</b>	<b>NAME OF RESPONSIBLE PARTY</b>
<b>RELATIONSHIP TO CLIENT</b>	<b>NAME OF SCHOOL/CURRENT GRADE</b>
<b>ADDRESS</b>	<b>CITY</b> <span style="float: right;"><b>ZIP</b></span>
<b>PREFERRED PHONE #</b> TYPE: <input type="checkbox"/> HOME <input type="checkbox"/> MOBILE <input type="checkbox"/> OTHER	<b>MAY WE LEAVE A MESSAGE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO

*For office use only:*

**DSM Code:** \_\_\_\_\_

SECTION 2 - Referral Information

**We appreciate our referral sources! May we inquire as to who referred you to our office?**

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SECTION 3 – Financial and Billing Information

**Primary Insurance Carrier Information**

<b>NAME OF INSURED</b>	<b>DATE OF BIRTH</b>		
<b>INSURANCE IDENTIFICATION #</b>	<b>POLICY # (if applicable)</b>		
	<b>GROUP #</b>		
<b>INSURED EMPLOYER</b>	<b>PHONE #</b>		
<b>NAME OF INSURANCE CO.</b>	<b>PHONE #</b>		
<b>ADDRESS OF INSURANCE CO.</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>

**Self - Pay client** (no insurance will be used).

*↻ Filing for Secondary Insurance is the client's responsibility.*

**CONSENT AGREEMENT – PAYMENT FOR SERVICES**

Your insurance coverage is an agreement between you and your insurance company. The consumer is ultimately responsible for any and all expenses incurred for treatment at the Hope Enrichment Center PC. We will file all claims for the services rendered at the Hope Enrichment Center, PC with your primary insurance carrier. If your insurance carrier does not pay its portion within 4 weeks of the filing date, and we have done everything in our power to effectively obtain payment for services, the consumer is ultimately responsible for your service fees. We will be diligent in communicating any insurance reimbursement difficulties with the consumer as this information becomes apparent to our billing department.

I hereby authorize *Hope Enrichment Center, PC.* to release any information required in the processing of claims.

I acknowledge and agree that the *Hope Enrichment Center, PC* has permission to send my case to a third party collection agency in the event that I neglect to pay for services in a timely fashion.

I understand that the cost per clinical hour is **\$250.00** for the Initial Evaluation and **\$175.00** follow-up sessions. In the event a credit is developed on your account, you have the option to apply said credit to future co-payments/co-insurance costs or your deductible. Consumers may also request to receive their account credit back in the form of a check from the *Hope Enrichment Center PC.* This request for a credit must be done in writing and submitted to the *Hope Enrichment Center PC* billing department. *The Hope Enrichment Center PC* has up to 30 business days after the request is submitted for said credit to be returned to the consumer.

I understand that there will be a **\$50.00 charge** for failed appointments (i.e. not canceling your appointment with 24 hour notice or failing your scheduled appointment time). There will be a **\$30.00 charge** for returned checks. Payment is due upon receipt of services. I also attest that I have received and read the General Policy Statement.

\_\_\_\_\_ (printed name)

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date

## SECTION 4 – What brings you in today?

### Have you had -

<input type="checkbox"/> Frequent mood changes	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Worry
<input type="checkbox"/> Change in sleep patterns	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Difficulty focusing
<input type="checkbox"/> Feel overwhelmed	<input type="checkbox"/> Crying spells	<input type="checkbox"/> Low motivation	<input type="checkbox"/> Racing thoughts
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Irritability	<input type="checkbox"/> Self injury	<input type="checkbox"/> Acting out/impulsivity
<input type="checkbox"/> Increased substance use	<input type="checkbox"/> Thoughts to harm self	<input type="checkbox"/> Thoughts to harm others	
<input type="checkbox"/> Other: _____			

### Recent stressors – (last 12 months)

<input type="checkbox"/> Marital issues	<input type="checkbox"/> Divorce/Separation	<input type="checkbox"/> Relationship conflict	<input type="checkbox"/> Remarriage
<input type="checkbox"/> Pregnancy/Miscarriage	<input type="checkbox"/> Sexual identity issues	<input type="checkbox"/> Infertility	<input type="checkbox"/> Parenting
<input type="checkbox"/> Major life transition	<input type="checkbox"/> Health/Medical issues	<input type="checkbox"/> Financial stress	<input type="checkbox"/> Traumatic event
<input type="checkbox"/> Loss of a loved one	<input type="checkbox"/> Issues at work/school	<input type="checkbox"/> Identity issues	<input type="checkbox"/> Aging parents
<input type="checkbox"/> Spiritual issues	<input type="checkbox"/> Legal issue	<input type="checkbox"/> Hospitalized for mental health or substance use	
<input type="checkbox"/> Other: _____			

### Health review – (last 4 weeks)

<input type="checkbox"/> Feel tired	<input type="checkbox"/> Feel like you are running on a motor	<input type="checkbox"/> Nausea	<input type="checkbox"/> Aches/pain
<input type="checkbox"/> Oversleeping	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Hot or cold spells	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Increase in weight	<input type="checkbox"/> Decrease in weight	<input type="checkbox"/> Headaches	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Rapid pulse	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Cardiac issue	<input type="checkbox"/> Diarrhea/Constipation
<input type="checkbox"/> Vomiting	<input type="checkbox"/> Broken bone/sprain/strain	<input type="checkbox"/> Hair loss	<input type="checkbox"/> Decreased sex drive
<input type="checkbox"/> Sexual performance concern		<input type="checkbox"/> Difficulty recovering after pregnancy	
<input type="checkbox"/> Missed menstrual period		<input type="checkbox"/> Cancer	<input type="checkbox"/> Surgery
<input type="checkbox"/> Hospitalization			
<input type="checkbox"/> Other: _____			

**Primary Healthcare Physician (PHP) :** \_\_\_\_\_ **Last visit:** \_\_\_\_\_

**Physician's address & phone number:** \_\_\_\_\_

**Release of Information for Primary Care Physician signed: YES NO**      **Date Signed:** \_\_\_\_\_

*Your therapist will ask questions about your health, medical background, family history and mental well being to better assess what areas to work on with you and start setting goals today.*

## SECTION 5 – Confidentiality and General Office Policies

**PLEASE REVIEW AND INITIAL BOTH PARTS.**

### Confidentiality and Privacy Policy

All sessions are confidential according to Illinois and federal law. However, we have a duty to prevent harm to you and others. Therefore, we are required by law to respond responsibly. Laws require us to report suspicion of child or elder abuse to either DCFS or the Department of Aging. We are also required to secure adequate care of those struggling with suicidal or homicidal thoughts and behaviors. If you have specific questions, please discuss them with your counselor.

With your permission, we will communicate with your insurance company in order to assist you in receiving your maximum health benefits. In most cases, insurance companies require us to reveal your diagnosis code and service code (e.g., individual psychotherapy visit). However, some companies require regular review of treatment goals, symptom severity, symptom changes/improvements, and therapy techniques utilized in treatment. If you have questions regarding this matter, please feel free to consult with your insurance company AND your counselor.

In some circumstances, mental health records and information may be subpoenaed for legal purposes. Please inform your counselor of any legal issues IMMEDIATELY and consult with your attorney for counsel on receiving mental health services. *A full explanation of our privacy policy is available to you upon request and you are encouraged to review it if you have any questions or concerns regarding your confidentiality rights.*

INITIALS \_\_\_\_\_

### General Office Policies

☞ APPOINTMENTS – Each therapist at the Hope Enrichment Center, PC is responsible for making their own appointments. Please consult with your individual therapist to both obtain and reschedule any and all appointments.

☞ SOCIAL MEDIAL POLICY – The Hope Enrichment Center, PC asks that you agree to review and sign our *Social Medial Policy* to ensure the highest level of ethical communication possible regarding your private health information.

☞ CANCELATION POLICY – The Hope Enrichment Center, PC asks that you respect our 24 hour cancelation policy. If you are in need of rescheduling or canceling an appointment, please provide your counselor with a 24 hour notice. This allows your therapist to place another client into that time slot and adjust his/her daily schedule accordingly. There is a \$50.00 charge for same day cancellations (less than 24 hour notice) and failed scheduled appointments. *In signing this document, you are acknowledging your agreement with this policy.*

☞ AFTER-HOURS or EMERGENCY NEEDS – Hope Enrichment Center office hours are Monday – Friday 9am – 7pm (Saturdays by appointment only). We are happy to return calls during regular business hours. If there is an emergency outside of our office hours, we encourage you to call 800-273-TALK, a 24 hour hotline, or 9-1-1.

☞ FEES/PAYMENTS – Our fees are \$250.00 for your initial evaluation/interview session. A 45-55 minute session is \$175.00. A 20-30 minute session is \$75.00. *Co-pays and deductible are due at the time of service.* We accept cash, personal check, or Visa, MasterCard, or Discover for payment. *There is a \$30.00 charge for any returned checks.*

☞ MEDICATIONS – The staff at the Hope Enrichment Center does not prescribe medications of any type. However, if you are in need of such services, we will be happy to refer you to a competent physician who can provide you with conservative medication management.

INITIALS \_\_\_\_\_

**CONSENT FOR TREATMENT**

The type of psychological treatment that you will be receiving is based on the research findings regarding the optimal methods of helping people effectively cope with and/or overcome a wide range of mental health conditions. The mental health conditions are described in detail in the Diagnostic and Statistical Manual of Mental Health Disorders – Fifth Edition (DSM-V). The specifics of your diagnosis will be discussed with you prior to you beginning treatment. Before beginning psychological treatment, a mental health history will be taken during an interview or interviews with your Hope Enrichment Center clinician. In addition, prior diagnostic evaluations that are related to mental health will be reviewed. These evaluations may include, but are not limited to, medical reports regarding health conditions, neurological functioning, neuro-psychological and psychological skills, Speech-Language, Occupational Therapy, and prior mental health diagnoses and treatment. Your Hope Enrichment Center clinician will discuss your initial diagnosis and treatment plan with you to ensure your understanding of the plan and proposed treatment.

Hope Enrichment Center provides a variety of mental health treatments, including:

- Individual psychological counseling that is structured to meet the needs of the specific person. The counseling approach for each individual is specifically tailored to that person’s mental health needs. Depending on an individual’s needs, several approaches to counseling may be incorporated into treatment, including: Cognitive and Behavioral Therapies (CBT & DBT), psychodynamic approaches, relational therapy, cognitive restructuring techniques, EMDR (Eye Movement Desensitization and Reprocessing), mindfulness, art therapy, movement therapy, performance enhancement, biofeedback, and neurofeedback.
- Family counseling.
- Marital counseling.
- Group counseling.
- Consultation with other mental health providers, schools, and medical service providers (with approved signature of release).

I, \_\_\_\_\_, agree to the above confidentiality, privacy, and general  
(please print your name)  
Policies, and Consent to Treatment of the Hope Enrichment Center, P.C.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree to communicate any and all changes in the above statements or policies of the Hope Enrichment Center, PC as they are established.

Therapist signature: \_\_\_\_\_ Date : \_\_\_\_\_

*↻ A copy of the confidentiality, privacy, Consent for Treatment and HEC general policies are provided to the client for their information.*

# Emergency Contact

## Release for Disclosure of Confidential Information

I, \_\_\_\_\_, date of birth, \_\_\_\_\_ authorize the release of  
(Print Client's Full Name)  
information regarding my current mental and physical health status to \_\_\_\_\_  
(Printed name of emergency contact)  
at (Emergency Contact's phone number) \_\_\_\_\_ in the event of an emergency. An emergency is defined here as an event or situation in which the client named above is unable to adequately care for him/herself due to lack of consciousness, severe physical illness, or client self report of suicidal/homicidal ideation. I understand that outside of these circumstances, the individual I have provided as my emergency contact will have NO access to my mental health records or treatment information at the Hope Enrichment Center, PC.

This information is being released for the purpose of keeping both the client and the general public safe from harm.

Expiration of Consent: This consent shall expire automatically upon the fulfillment of the purpose stated herein. Additionally, this consent will expire on \_\_\_\_\_, 20\_\_\_\_\_.

Right to Revoke: This release is voluntary on my part. I may take back this consent at any time, except to the extent that action based on this consent have already been taken.

Authorization: I hereby authorize the information described above to be released to the party identified on this form.

Signature of patient	Printed name of patient	Date
Signature of Witness	Printed name of Witness	Date

I

1 Copy for patient

1 Copy for Hope Enrichment Center, P.C.

1 Copy for recipient