Living Hope Counseling Center

Client Information

Primary Client:

Name			
Address			Apt
City		State	Zip
Home Phone	Work Phone		
Cell Phone	Text? Y N		Voicemail? Y N
Email Address			
Marital Status S M WID SEP DIV			SEX: M F
Employer			
Date of Birth	SS #		
Are there any special instructions about contacting you at home or work? _____			

Parent/Spouse/Partner:

Name			
Address			Apt
City		State	Zip
Home Phone	Work Phone		
Cell Phone			
Marital Status S M WID SEP DIV			SEX: M F
Employer			
Date of Birth	SS #		
Are there any special instructions about contacting you at home or work? _____			

Please list other people in your home:

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Your signature is required on the back page

History:

How did you hear about Living Hope Counseling Center? _____

Have you had prior counseling? _____

Physician _____

Current Medications _____

Counseling Goals:

What caused you to begin counseling? _____

What do you want to accomplish through counseling? _____

Spiritual:

How important is religion or spirituality in your life? _____

Do you attend church?	Regularly	Occasionally	Never

Where do you attend? _____

Optional: **Answering the following questions is optional – however, it will help us to serve you better.**

Are you happy with yourself? _____

What do you like about yourself? _____

Are you happy with your marriage/relationship? _____

What do you wish was different in your marriage/relationship? _____

Do you feel in control of your financial situation? _____

What major changes have you gone through in the past two years? _____

Do you use alcohol or other drugs	Regularly	Occasionally	Never

SIGNATURE **DATE**

LIVING HOPE COUNSELING CENTER
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: May 2015

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 CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
    - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
    - is not part of your medical or billing records;
    - is not available for inspection as set forth above; or
    - is accurate and complete.

    In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
    - to carry out treatment, payment and health care operations as provided above;
    - to persons involved in your care or for other notification purposes as provided by law;
    - to correctional institutions or law enforcement officials as provided by law;
    - for national security or intelligence purposes;
    - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
    - incidental to other permissible uses or disclosures;
    - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
    - made to patient or their personal representatives;
    - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Sarah Benitone, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Living Hope Counseling Center or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Living Hope Counseling Center
Becky Lacy
Privacy Officer
3000 Lenhart Road
Springfield, IL 62711
217-698-7150
217-698-8151

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site for downloading.

Living Hope Counseling Center

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ **Patient ID #:** _______________________

I hereby acknowledge that I have received a copy of Living Hope Counseling Center's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

____
Signature of Patient or Legal Representative

____
Date

____
Printed Name of Patient's Representative (*if applicable*)

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

- -

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date,

_____________________________ but acknowledgment could not be obtained because:

- ☐ Patient/representative refused to sign
- ☐ Emergency situation prevented us from obtaining acknowledgement at this time (will attempt again at a later date)
- ☐ Communication barriers prohibited obtaining acknowledgement (Explain)

____

____

____

____

____

- ☐ Other (Specify)

____

____

____

____

____

LIVING HOPE COUNSELING CENTER

A Statement of Confidentiality

The Illinois Mental Health and Developmental Disabilities confidentiality Act, the Federal Act regarding Confidentiality of Alcohol and Drug Abuse Patient Records, as well as the Ethical Standards of the American Association for Counseling and Development, the National Association of Social Workers and other professional organizations state that the counseling relationship must be kept confidential.

Confidentiality may be broken under the following circumstances:

1. To report suspected child or elder abuse or neglect. (Required by state law.)

2. In the event you threaten harm to yourself or other people.

3. Information will be released to your insurance company as necessary to process your claim.

4. If records or information is subpoenaed by a court, information will be released only to the extent required by law.

5. Name and identifying information only may be released if necessary to enlist the services of a collection agency.

Your counselor will be discussing your progress with supervisory staff for the purpose of supervision/consultation only. These discussions are kept confidential.

Any other release of information regarding the counseling services you receive will be made only with your expressed permission.

I have read the above information carefully and understand the counselor's social and economic responsibility to make such decisions where necessary.

_____ _____

SIGNATURE **DATE**

Living Hope Counseling Center
3000 Lenhart Rd.
Springfield, Il. 62711

Informed Consent for Treatment

1. I understand that as a part of the healing and growth process, I may experience initial discomfort or worsening of symptoms. This may be as a result of the issues being addressed in counseling.
2. I understand not all people benefit from counseling.
3. I understand if I do not pay for services as agreed, further services will be suspended until my account has been brought current.
4. I understand I will be charged 1.5% of my unpaid balance every 30 days, unless consistent effort has been made to eliminate my debt.
5. I understand Living Hope Counseling Center does not have an answering service. Clients may leave a confidential voicemail message for their counselor at the Center or may call the counselor's after hour's number and calls will be returned as soon as they are received.
6. I understand there will be times my counselor is out of town. When they are out of town, their emergency calls will be covered by another counselor on staff.
7. I understand if my counselor cannot be reached, it is my responsibility to seek another resource by calling 9-1-1 or go to the nearest emergency room for assistance.
8. I understand I have the right to know my treatment goals, short-term objectives and therapeutic interventions.
9. I understand I may choose to decline certain therapeutic interventions.
10. I understand no audio or video recordings will be made of my sessions unless I grant permission in writing.
11. I understand my counselor meets the requirements of the Illinois State Department of Regulations. My counselor is not a physician/medical doctor and does not practice medicine. If medical treatment or medicine is required, my counselor will recommend I see a physician. My counselor takes no responsibility for services provided by other professionals.
12. I understand I have the right to end counseling at any time without moral or legal obligation.
13. I understand my counselor reserves the right to end counseling at any time. Referrals to another counselor will be made at that time, if requested by the client.

_____ _____

CLIENT SIGNATURE **DATE**

By signing this consent agreement, I confirm I have read or have had someone read to me the above understandings.

OFFICE COPY **CLIENT NAME: _____**

LIVING HOPE COUNSELING CENTER
MISSED OR CANCELLED APPOINTMENT POLICY

Your scheduled appointment has been reserved for you. If you need to cancel an appointment, **please call the counselor at least 24 hours before your scheduled appointment to avoid being charged for the session**.

Please discuss with your counselor the best phone number for cancelling an appointment. If you contact the office at 217-698-7150 and need to leave a message, please leave the message directly on your counselor's voicemail.

FEE SCHEDULE:

Cancelled appointment with 24 hours or more notice – no charge
Cancelled appointment with less than 24 hour notice - $30 (except in dire emergencies)
Missed appointment (no call, no show) fee is $60

NOTE: The fee charged for the missed appointment or late cancellation notice must be paid to re-establish services at Living Hope Counseling Center. Please make payment arrangements by contacting the main office or contacting your counselor directly.

The counselor has the right to cancel a client after missing three sessions.

Insurance is not billed for missed appointments.

PHONE CONSULTATION POLICY

You may call your counselor if a crisis arises. **If an emergency is life threatening**, you need to go to the nearest hospital emergency room for a medical evaluation. Your counselor can follow the guidelines below for charging you for repeated phone calls:

* Under 10 minutes, no charge
* 11-30 minutes = 1/2 session fee
* 31-55 minutes = full session fee

Most insurance companies will not cover telephone consultations.

I have read and understand the above information regarding cancellations and missed appointments. By signing this form, I agree to the terms stated above.

_____ _____

CLIENT SIGNATURE **COUNSELOR SIGNATURE**

_____ _____

DATE **DATE**

CLIENT COPY

LIVING HOPE COUNSELING CENTER
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_____	_____
CLIENT SIGNATURE	**COUNSELOR SIGNATURE**
_____	_____
DATE	**DATE**