

Living Hope Counseling Center

Child or Adolescent Information

Client Information		Acct ID (Office Use Only)	
Legal Name		Preferred or Nick Name	
Address		City, State, Zip	
Date of Birth		Age	Grade
Gender	Race/Ethnicity	Cell Phone (May we text or message you? Y N)	
School Name and City			
Parent/Guardian Information			
Name		Relationship to Client	
Address			
Date of Birth		Gender	Race/Ethnicity
Relationship to Client		Parent Marital Status: S M D	
Cell Phone		Other Phone	
Email Address <i>Email is not a secure method of communication. Do you consent to Living Hope sending you administrative emails? Y N</i>			
Employer		Occupation	
Second Parent/Guardian Information			
Name		Relationship to Client	
Address			
Date of Birth		Gender	Race/Ethnicity
Relationship to Client		Parent Marital Status: S M D	
Cell Phone		Other Phone	
Email Address <i>Email is not a secure method of communication. Do you consent to Living Hope sending you administrative emails? Y N</i>			
Employer		Occupation	

Other Parent/Guardian Information		
Name	Relationship to Client	
Address		
Date of Birth	Gender	Race/Ethnicity
Relationship to Client		Parent Marital Status: S M D
Cell Phone	Other Phone	
Responsible Billing Person(s):		

Please list other people in your home:		
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Other Information		
List any prior counseling or psychiatric services and clinician's name:		
Current physician		
Current Medication		
Why did you decided to begin counseling? (If the parent/guardian is completing form, please answer what occurred for you to be concerned about your child and to decided to seek counseling.)		
What do you want to accomplish through counseling?		
What do you like about yourself?		
How important is religion or spirituality in your life?		
Do you attend church? Y N Where do you attend?		

Client Signature

DATE

Parent/Guardian 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.



CLIENT FINANCIAL AGREEMENT AND POLICY ACKNOWLEDGMENT

Client Name: _____ Client ID: _____ Date: _____

___ **Payment of session fees:** Living Hope Counseling Center (LHCC) collects the session fee, insurance copay, coinsurance, deductible amount or other charges at the time of the session unless other prior arrangements have been made with the administrative office.

___ **Information Change:** It is the client's responsibility to inform providers when information changes including address, phone number and insurance coverage.

___ **Payments Accepted:** Cash, checks, credit, debit, FSA and HSA cards are accepted. A returned check fee charged for all checks returned for any reason.

___ **Billing Statements:** Statements are sent on a monthly basis. The balance is due within 15 days unless arrangements are made with the administrative office.

___ **Reports, Consultations and Court Appearance:** Reports for probation, court, disability, FMLA and letters to physicians, teachers, schools and other requested paperwork are charged according to the current schedule of fees. All reports and court appearance fees must be paid in advance of receipt of report or court appearance. These fees are not typically covered by insurance and will not be billed to your insurance.

___ **Phone Consultation:** 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 and charge for repeated phone call. Phone calls are not typically covered by insurance and will not be billed to your insurance.

___ **Cancelled and Missed Appointments:** Your scheduled appointment has been reserved for you. If you need to cancel an appointment, please provide notice at least 24 hours prior to the scheduled appointment time to avoid being charged a late cancellation fee. Providing adequate notice when you cannot make an appointment allows the counselor to offer the appointment time to another client. Failure to provide notice will result in a missed appointment fee. The cancelled and missed appointment fees are charged at the discretion of the counselor. These fees may be waived in the case of illness or emergency. The counselor reserves the right to cancel a client after missing three sessions.

___ **Payment of Missed or Cancelled Appointments:** All outstanding missed appointment fees must be paid prior to scheduling a new appointment or attending the next scheduled appointment for services at LHCC. These fees are the client's responsibility and will not be billed to any third-party paying for the services including insurance, EAP, church partner, etc. Please contact the administrative office to make this payment or bring payment to the session.

___ **Financial Responsibility:** The client is financially responsible for all charges including the balance remaining after payment of insurance benefits, charges for services not covered by insurance, missed appointment or late cancellation fees, report writing fees, court appearance fees, and any other billing charges deemed appropriate for services rendered. If payments are not made as agreed, your account may be turned over to a collection agency after 60 days delinquency.

___ **Acknowledgement of Receipt of Privacy Notice:** My signature below constitutes my acknowledgement that I have been provided a copy of Living Hope Counseling Center's Notify of Privacy Practices that describe in detail how my healthcare information is used and shared with others. I understand my rights and responsibilities as they related to the Privacy Notice. I understand that Living Hope Counseling Center reserves the right to change the Privacy Notice at any time. I may obtain a current copy of the Privacy Notice by contacting Living Hope Counseling Center's Privacy Office at 217-698-7150 (ext 101) or by visiting the Living Hope Counseling Center website (www.livinghopecounselingcenter.org).

INSURANCE AND EAP CLIENTS: Verification of insurance coverage, obtaining referrals and pre-certification is the responsibility of the client. Providing updated insurance information and required authorizations is also the client's responsibility.

Insurance and EAP Authorization and Assignment of Benefits: With regards to using an insurance carrier or employee assistance plan (EAP) for counseling services rendered by LHCC, I hereby assign, transfer and set over to LHCC all of my rights, title and interest to healthcare reimbursement. If payment is received from more than one source causing overpayment for this period of counseling, I authorize application of the overpayment to any unpaid counseling bill for which I am responsible. I hereby authorize LHCC to release to any insurance carrier coded diagnostic and procedural information necessary for the completion of my counseling claim for payment purposes. I release and authorize LHCC to discuss details of my counseling with my insurance carrier and/or designated review agent.

For couples: Who is covered under the insurance plan(s) below? _____
Primary Insurance: _____ Member ID _____ Group No _____
Policy Holder Name if different from client: _____ Date of Birth _____
Relationship to Client: _____ Policy Holder Address: _____

Second Insurance (if applicable): _____ Member ID _____ Group No. _____
Policy Holder name if different from client: _____ Date of Birth _____
Relationship to Client: _____ Policy Holder Address: _____
(Please present your insurance card(s) to LHCC staff for copying)

Employee Assistance Plan _____
Authorization or Referral No. _____ #of Sessions _____ Expiration Date: _____
(Please present to LHCC staff for copying any paperwork provided to you by your EAP)

SLIDING SCALE RATES: Our fees for clients who do not have insurance coverage are based on annual household income.

All rates other than the standard rate require income verification.

___ I will be paying the standard rate of \$150 per 60-minute session.

___ I qualify for and will be paying the sliding scale rate of \$ _____ per 60-minute session. I have provided my required income-verification to LHCC staff for review. If I have not provided the required documentation, I understand that I will pay the full standard rate of \$150 per 60-minute session until I have provided the required documentation for review.

CHURCH PARTNER RATES – CLIENT PAID: I verify that I attend [partner church] _____ and understand I will receive up to six (6) 60-minute sessions paying \$60 per session. The \$60 per session fee is my responsibility as the client and LHCC will not bill the church for this fee. These 6 sessions will not be billed to insurance. I understand that upon completion of the 6 sessions, if I choose to continue services, I may switch to another payment option available to me.

THIRD PARTY PAID: [third party name] _____ has agreed to pay for _____ 60-minute counseling sessions for me. I acknowledge and grant LHCC permission to provide billing information to the above-name third party representative. I understand that upon completion of the above number of sessions, if I choose to continue services, I may switch to another payment option available to me.

CLIENT SIGNATURE: I acknowledge I have read and understand the above initialed policies, rates and financial responsibilities. I agree to the above terms. _____ SIGNATURE OF CLIENT DATE	LHCC STAFF MEMBER SIGNATURE: I have discussed the above initialed information with the client. _____ SIGNATURE OF STAFF DATE
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LIVING HOPE COUNSELING CENTER
3000 Lenhart Road, Springfield, IL 62711

Informed Consent for Treatment

- 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.
- I understand not all people benefit from counseling.
- I understand if I do not pay for services as agreed, further services will be suspended until my account has been brought current.
- I understand that 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-hours number and calls will be returned within 24 hours or the next business day.
- I understand there will be times my counselor is out of town. During that time emergency calls will be covered by another counselor on staff.
- I understand if my counselor cannot be reached, it is my responsibility to seek another resource by calling 911 or go to the nearest emergency room for assistance.
- I understand I have the right to know my treatment goals, short-term objectives and therapeutic interventions.
- I understand I may choose to decline certain therapeutic interventions.
- I understand no audio or video recordings will be made of my sessions unless I grant permission in writing.
- 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.
- I understand that I have the right to end counseling at any time without moral or legal obligation.
- 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.

Statement of Confidentiality

Confidentiality is an important aspect of counseling. Confidentiality means that no one outside Living Hope Counseling Center (LHCC) is given any information, including the fact that you have been here, without your expressed written consent. Our goal is to provide you with a safe environment in which you feel comfortable to discuss your concerns.

The LHCC staff members follow the professional, legal, and ethical guidelines set forth by the professional regulations of the State of Illinois and various Federal confidentiality acts in keeping the counseling relationship confidential. Please be aware that there are certain circumstances in which therapists are required to breach confidentiality without a client's permission:

- To report suspected child or elder abuse or neglect.
- In the event you threaten harm to yourself or other people.
- Information required by your insurance company as necessary to process your claim.
- Under court order. If records or information is subpoenaed by a court, information will be released only to the extent required by law.

Your counselor will be discussing your progress with supervisory staff for the purpose of supervision or 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 written permission.

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

CLIENT SIGNATURE

DATE

Living Hope Counseling Center
Springfield, Illinois
Standard Schedule of Fees

Individual Therapy, hourly rate	\$150
Sliding Scale Rate hourly rate*	\$80
Sliding Scale – hourly rate (16 sessions) *	\$50
Sliding Scale – hourly rate (9 session) *	\$20
Partner Church Rate (6 sessions) **	\$60
Cancelled Session less than 24 hours	\$30
Missed Session	\$60
NSF Check Fee	\$25
Phone Consultation (11 – 30 minutes)	\$25
Phone Consultation (31 – 45 minutes)	\$50
Correspondence / Report	\$50
Court Appearance – hourly rate (2 hours minimum)	\$50

RATE ->	\$20 Per Session*	\$50 per session*	\$80 per session*	\$150 per session
FAMILY SIZE	Annual Household Income Level			
1 person	< \$24,980	\$25,000 - \$31,225	\$31,230 – \$49,950	\$49,960 and up
2 people	< \$33,820	\$33,830 - \$42,275	\$42,280 - \$67,630	\$67,640 and up
3 people	< \$42,660	\$42,670 - \$53,325	63,990 - \$85, 315	\$85,320 and up
4 people	< \$51,500	\$51,510 – \$64,375	\$77,250 - \$102,999	\$103,000 and up
5 people	< \$60,340	\$60,350 - \$75,425	\$90,510 - \$120,670	\$120,680 and up
6 people	< \$69,180	\$69,190 - \$86,475	\$103,770 - \$138,350	\$138,360 and up
7 people	< \$78,020	\$78,030 - \$97,525	\$117,030 - \$156,030	\$156,040 and up
8 people	< \$86,860	\$86,870 - \$108,575	\$130,290 - \$173,510	\$173,520 and up
Each additional person	\$4,420	\$8,840	\$13,260	N/A

*Requires client to complete a Sliding Scale Rate Application and provide income documentation

**Church partner rate is extended to active members of one of our current church partners.