LINCOLN PARK
THERAPY GROUP
COURAGE • COMPASSION • CHANGE

COUNSELING INTAKE FORM

Note: This information is confidential.

Demographic Information:

Name:	Date:
Date of Birth: / / Place:	Relationship Status:
Age:	Gender: M / F # of Dependents:
Mobile Phone:	Is it ok to leave a message for you at this number? Y / N
Email:	Is it ok to email you? Y / N
Is it ok to text you? Y/N Initial Here_____	Please note that texting is not secure and not to use it if you are concerned about your privacy.
Mailing Address:	
City, State:	Zip Code:
Current Employer:	Position Title:
Current Occupational Status: (i.e., F/T, P/T, self-employed, student, returning to work):	
Medical Doctor's Name:	Medical Doctor's Phone #:
Psychiatrist's Name:	Psychiatrist's Phone #:
Emergency Contact Name:	
ER Contact Relationship:	Emergency Contact Phone:

I authorize Lincoln Park Therapy Group to make contact with my emergency contact in the event of an emergency.

Signature_____Date_____

Current Concerns: What concern brings you in?

Estimate the severity of this concern: Mild Moderate Severe Very Severe

When did this concern begin (give dates)?

Please describe significant events occurring at that time, or since then, which may relate to the development or maintenance of this concern:

Are you having any difficulties/stressors in your current job? If so, please briefly describe those difficulties.

What do you hope to accomplish in counseling?

Are you having problems with your sleep? __Yes __No

Behavior – circle any of the following behaviors that apply to you:

Overeat	Suicidal attempts	Can't keep a job	Take drugs	Compulsions
Insomnia	Vomiting	Smoke	Take too many risks	Odd behavior
Withdrawal	Lack of motivation	Drink too much	Nervous tics	Eating problems
Work too hard	Procrastination	Sleep disturbance	Crying	Impulsive reactions
Avoidance	Outbursts of temper	Loss of control	Aggressive behavior	Concentration difficulties

Feelings – circle any of the following feelings that apply to you:

Angry	Guilty	Unhappy	Annoyed	Happy	Bored	Sad
Conflicted	Restless	Depressed	Regretful	Lonely	Anxious	Hopeless
Contented	Fearful	Hopeful	Excited	Panicky	Helpless	Optimistic
Energetic	Relaxed	Tense	Envious	Jealous	Others:	

Physical – circle any of the following symptoms that apply to you:

Headaches	Stomach trouble	Skin problems	Dizziness	Tics
Dry mouth	Palpitations	Fatigue	Burning or itchy skin	Muscle spasms
Twitches	Chest pains	Tension	Back pain	Rapid heart beat
Sexual disturbances	Tremors	Unable to relax	Fainting spells	Blackouts
Bowel disturbances	Hear things	Excessive sweating	Tingling	Watery eyes
Visual disturbances	Numbness	Flushes	Hearing problems	Don't like being touched

Health Information:

Do you have any current concerns about your physical health? Please specify:

Past/present medical conditions and treatment outcome, if any:

Please list medicines you are currently taking, or have taken during the past 6 months (include any medicines that were prescribed or taken over the counter):

Medication Dose For what? Prescribed by whom? Date of last visit:

Do you get regular exercise? If so, what type and how often?

Check any of the following that apply to you:

	Never	Rarely	Frequently	Very Often		Never	Rarely	Frequently	Very Often
Marijuana					Heart problems				
Tranquilizers					Nausea				
Sedatives					Vomiting				
Painkillers					Insomnia				
Cocaine					Headaches				
Alcohol					Early morning awakening				
Coffee					Fitful sleep				
Cigarettes					Binge / Purge				
Narcotics					Poor appetite				
Stimulants					Forgetfulness				
Hallucinogens					Lack of interest in activities				
Compulsive Exercise					High blood pressure				

Treatment History:

Therapist/Hospital **Length** **Initial Reason** **Goals/Outcome**

If you have received therapy in the past, what did you like about the process? What would have made it better?

Suicide Thoughts/ Attempts:

Have you had suicidal thoughts recently? ___Frequently ___Sometimes ___Rarely ___Never

Do you have a plan to act on your suicidal thoughts? __Yes __No

Have you had suicidal thoughts in the past? ___Frequently ___Sometimes ___Rarely ___Never

Have you ever developed a plan or acted on your suicidal thoughts? __Yes __No

If yes, please describe what your plan was and/or what interventions were used to keep you safe.

Previous Attempts:

Age Reason Circumstance Description

Relationship & Family History:

Past & Present Marriage(s)/Long-Term or Living Together Relationships:

Name Dates of Years Together Brief statement about the relationship

Describe your parents' relationship with each other: _____

Name Age Occupation Personality How did s/he treat you?

Father:

Mother:

If parents divorced: Your age at the time: _____ Describe how it affected you at the time:

Your parents' or other family members' physical health problems/illnesses, chemical use, and mental or emotional difficulties, abuse, and/or hospitalization:

Relationship with Siblings

Name Age Brief Statement about the Relationship

Relationship with Children Name Age Brief Statement about the Relationship

Abuse History: ☐ I was not abused in any way ☐ I was abused

If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Chemical Use:

Have you ever felt the need to cut down on your drinking? __ No __ Yes

Have you ever felt annoyed by criticism of your drinking? __ No __ Yes

Have you ever felt guilty about your drinking? __ No __ Yes

How much beer, wine, or hard liquor do you consume each week, on average?

Which recreational drugs have you used in the last 10 years & how frequently?

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:

Social:

Please describe your current support system: Friendships, Community & Spirituality – describe quality, frequency, activities, etc:

What gives you the most joy or pleasure in your life?

What are your most important hopes and dreams?

Are you involved in any current or pending civil or criminal litigation/s, lawsuit/s, or divorce/custody disputes? If yes, please explain:

LINCOLN PARK
THERAPY GROUP
COURAGE • COMPASSION • CHANGE

CLIENT CONSENT TO TREATMENT & PAYMENT POLICY

I, _____, hereby retain and request to receive professional services from Lincoln Park Therapy Group.

Initial_____ **Consent to Treatment** is not easily described in general statements. It varies depending on the personalities of the psychotherapist and client, and the particular difficulties that you bring forward. There are many different methods that I may use to deal with the difficulties that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on the things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are no guarantees of what you will experience.

Although our sessions may be very intimate both emotionally and psychologically, it is important for you to realize that we have a professional relationship rather than a personal one. Our contact will be limited to the paid sessions that you have with me. You will best be served with our relationship remaining strictly professional and if our sessions concentrate exclusively on your concerns. Therefore, it is important for you to remember that you are experiencing me only in my professional role.

Initial_____ **Problem Resolution** If at any time you are dissatisfied with my services, please let me know. If I am not able to resolve your concerns, you may report your complaints in writing to Secretary of Health & Human Services, 200 Independence Avenue, Washington, DC 20201.

Initial_____ **Records and Confidentiality** All of our communications become part of the clinical record, which is accessible to you on request provided that in my estimate viewing your record will not cause psychological or emotional harm. I will keep confidential anything you say to me, with the following exceptions: (1) you direct me in writing to tell someone else, (2) I determine you are a danger to yourself or others, (3) I am ordered by a court to disclose information, and (4) other disclosures as outlined in the "Illinois HIPAA Notice" that you have been provided.

Initial_____ **Consultation with other Professionals** I regularly consult with other professionals regarding my clients; however, your name or other kinds of identifying information is never mentioned. Your identity will remain completely anonymous during such consultations and confidentiality is fully maintained.

Initial_____ **Mandated Reporter** As a Mental Health Professional, I am mandated to report certain activities that are deemed illegal in the state of Illinois. These include actual and/or suspected child abuse and

neglect, actual and/or suspected child molestation and actual and/or suspected pedophilia. This also includes suspected or actual abuse and neglect directed towards an elderly person.

Initial_____ Litigation Limitation Due to the nature of the therapeutic process and the fact that it often involves making a full and honest disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you ("client") nor your attorney, nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the counseling records be requested.

Initial_____ Mediation and Arbitration All disputes arising out of or in relation to this agreement to provide counseling services shall be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. Therefore, the mediator shall be a neutral third party chosen by agreement of between you and me (Client and Therapist). The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Cook County, Illinois in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, I can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

Initial_____ Response to Client Communication: Every reasonable effort is made to return Client(s) calls, emails and text messages in a timely manner. Clients can expect a return response within one business day. The Client should leave her/his name and at least one telephone number on the voice mail message, as messages may be checked from a remote location. Practitioner will inform Client(s) in advance of any expected absence. Client acknowledges that texting and emailing is limited to scheduling issues, is not secure, may not be read everyday and should not be used for urgent or emergency issues.

Initial_____ Emergencies: This Practitioner does not provide emergency mental health services. Should Client(s) experience a mental health emergency s/he should call or go the closest hospital Emergency Room, the closest community/county mental health center, the psychiatrist or other family physician or dial 911. Once emergency care has been obtained, Client(s) should advise Practitioner of status.

Initial_____ Privacy Policies: I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lincoln Park Therapy Group's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Nicolle Osequeda at 312.259.2665 or Nicolle@LincolnParkTherapyGroup.com.

I also acknowledge Lincoln Park Therapy Group's **payment policy**:

Initial_____ 1. A 55-60 minute Initial Intake session will be billed at the rate of $175.00 & subsequent 50-55 minute sessions are billed at the rate of $150 with Nicolle Osequeda, LMFT. A 55-60 minute Initial Intake session will be billed at the rate of $150.00 and subsequent 50-55 minute sessions are billed at $130 with Associate Therapists.

Initial_____ 2. Unless 24 hours advance notice is provided to Lincoln Park Therapy Group of my inability to appear for any scheduled appointment(s), I will be charged a rate of $150 for scheduled appointments with Nicolle Osequeda and $130 for appointments with Associate Therapists.

Initial_____ All no shows will be charged $150 for scheduled appointments with Nicolle Osequeda and $130 for appointments with Associate Therapists.

Initial_____ All fees will automatically be charged to the credit card on file

Initial_____ 3. If I cancel more than two appointments in a row I understand that in order to make a third appointment I must pay in advance.

Initial_____ 4. For phone consultations the fee will be as follows: For calls under 15 minutes there will be no charge, for calls lasting 15-30 minutes I will be billed for half of a session, and for calls over 30 minutes I will be billed for a whole session. Phone consultations and phone sessions are not covered by insurance and will be charged to the credit card on file.

Initial_____ 5. When requested by client or court of law to complete paperwork including but not limited to reports, letters, complete documents, or appear in court, I may be billed, at the discretion of Lincoln Park Therapy Group, for the actual time expended at the therapist's hourly rate with a 15-minute minimum billing interval. Paperwork requests are not covered by insurance and will be charged to the credit card on file.

Initial_____ 6. Court reports, fees and appearances including but not limited to attorney fees, out of pocket expenses and the like are the financial responsibility of the patient and will be charged to the card on file.

Initial_____ 7. By requesting that insurance claims be submitted on my behalf, I expressly assign to Lincoln Park Therapy Group any and all payments to which I am entitled for the services that have been provided to me. In doing so, I specifically authorize and instruct my health insurance provider to remit payments for these services directly to Lincoln Park Therapy Group.

Initial_____ 8. Payment of copayments, patient portions and balances due are expected at the time of service.

Initial_____ 9. Lincoln Park Therapy Group will submit a claim for the current services to insurance carriers. Insurance carriers are required to pay their portion of the claim within 45 days of receipt. If an insurance carrier delays or withholds payment of its portion for more than **90 days from the date of service**, both the insurance and patient portions of the account then become my responsibility. Lincoln Park Therapy Group office policy is to automatically charge the credit card on file for any outstanding balance after my account becomes more than 90 days past due. If Lincoln Park Therapy Group subsequently receives payment from an insurance carrier, they will credit my account for the amount of the payment.

Initial_____ 10. I understand that if a check that is written is returned to Lincoln Park Therapy Group for insufficient funds there will be a $30.00 fee assessed in addition to any bank fees. This will be charged to the credit card on file.

Initial_____ 11. After an insurance carrier pays its portion of the claim, I may be responsible for the patient portion, due to such factors as copayments or unmet deductibles, as outlined in my particular insurance plan. Lincoln Park Therapy Group will send a billing statement outlining this patient portion. I will have **7 days** from the date of the billing statement to submit payment for these charges, after which time Lincoln Park Therapy Group will automatically charge my credit card for the entire amount of the patient portions. If my credit card is refused, there will be a $30.00 fee assessed.

Initial_____ 12. If my balance due is over $200.00, or if more than two co-pays are unpaid, I understand that I cannot schedule another session until my account is paid in full.

I presently carry medical/behavioral health insurance with: _____

ID Number _____ Group Number_____

DOB of Insured _____DOB of Client (if different) _____

Credit Card Authorization

I hereby authorize Lincoln Park Therapy Group to charge my credit card for outstanding balances and patient portions owed to Lincoln Park Therapy Group, as provided in this Payment Policy.

Name of Cardholder:_____

Name of Client:_____

Type of Card: ____Visa ____MC ____AMEX

Card Number:_____

Exp Date: ____/____ Security Code:_____

Billing Address:_____

_____ , IL _____

Authorized Signature:_____

Date:_____

I understand that this document is a legal contract that is enforceable under the laws of the State of Illinois. I further acknowledge that I have fully read and understand each of the terms described above. I have received a copy of this document.

_____ _____
Client Signature Date

_____ _____
Signature of Parent or Guardian if Client is under 18 years of age Date

_____ _____
Psychotherapist Date
Lincoln Park Therapy Group

Lincoln Park Therapy Group strongly suggests that you monitor your account and the explanation of benefit forms that you receive from your insurer. You should resolve all disputes involving patient portions and explanation of benefits directly with your insurance carrier.

LINCOLN PARK
THERAPY GROUP
COURAGE • COMPASSION • CHANGE

NOTICE OF PRIVACY PRACTICES RECEIPT AND ACKNOWLEDGMENT OF NOTICE

Client Name: _____

DOB: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Lincoln Park Therapy Group's Notice of Privacy Practices. I understand that if I have any questions regarding the notice or my privacy rights, I can contact Lincoln Park Therapy Group at 312-259-2665

_____ _____
Client Signature Date

_____ _____
Signature of Parent or Guardian if Client is under 18 years of age * Date

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ **Client Refuses to Acknowledge Receipt**