The Kennedy Center for Counseling

305 N. Vine Street, Unit 201, New Lenox, IL 60451

Phone: 815-320-3749 Fax: 815-320-3825

Child & Adolescent Intake Form (Ages 1-17)

Today's Date: _____

Client's First Name: _____ Middle: _____ Last: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Gender: _____ Preferred Gender/Pronouns if different: _____

Birth date: _____ Email Address: _____

(Office Use Only) Diagnosis Code: _____ Therapist: _____

Primary Insurance Policy Information:

Insurance Company: _____

Address: _____ City, State, Zip: _____

Policy ID#: _____ Group #: _____

Phone: _____ Employer Name: _____

Subscriber's Name: _____ Birth date: _____

Responsible Party's Social Security Number (last 4 digits): _____

Client's Relationship to the Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Are you utilizing EAP services? Yes ☐ No ☐

If yes, what is the name of EAP? _____

EAP Authorization code/number: _____ Expiration Date: _____

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/insurance benefits to myself or to The Kennedy Center for Counseling.
I authorize payment of medical benefits to The Kennedy Center for Counseling for services provided.

Signed: _____ Date: _____

The Kennedy Center for Counseling

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Notice of Privacy Practices - Summary

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.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. Though these laws are complicated, we must provide you with this important information. These two pages summarize the Notice of Privacy Practices which you received along with this. You may refer to the complete document for more information. We realize that it is not possible to cover all scenarios in this document, so please consult our Privacy Officer, Owner Rita Sanders if you have further questions or concerns.

The health information we will obtain will be documented primarily from you, but may also include information obtained from other family members or professionals involved in your case that you have given us permission to speak with. This information will be used to provide you with effective treatment, to arrange payment for our services or for other business activities, which are called, in the law, health care operations. After you have read this NPP we will ask you to sign a form acknowledging that you have received this notice. If you are not willing to sign this form, we cannot treat you.

If information regarding your treatment here needs to be disclosed to others for family involvement or for coordination of treatment services we will discuss this with you and ask you to sign an Authorization to allow this.

We will keep all of your health information private. However, there are some situations where the law requires us to disclose information about you even without your signed consent, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

See the complete text of the NPP for the full list of mandated disclosure scenarios.

Your rights regarding your health information

1. You have the right to determine how we get in touch with you if we need to (for appointment changes or cancellations). Let us know if you prefer us to call your home or your cell and whether it is okay to leave a message.

2. You have the right to determine what information is shared with others involved in your treatment.

3. You have the right to review your record, and can request a copy of your record (medical and billing).

4. If you believe the information in your records is incorrect or incomplete, you can request that changes or amendments be made to them. This request must be made in writing, and must include reasons for the request.

5. You have the right to receive a copy of this notice. If our Privacy Practices are changed, we will post a notice in our waiting room and a copy can be requested.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Rita Sanders, phone number 815-320-3749, 305 North Vine Street, Unit 201, New Lenox IL 60451.

The effective date of this notice is April 14, 2003

Notice of Privacy Practices: Receipt and Acknowledgment of Notice

Patient/Client Name:_____DOB_____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of The Kennedy Center Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Rita Sanders, 815-320-3749.

I also verify that I understand the following:

All the information in my sessions is confidential **EXCEPT:**
If I am threatening to hurt myself, if I am threatening to hurt someone else, or if I tell of a child or an elderly person being abused, then the therapist must tell someone to protect me or another.

CONSENT TO TREATMENT

I hereby authorize and voluntarily consent to all care, treatment, and other related services that may be ordered, requested, directed, or provided by The Kennedy Center providers.

I understand and agree to the above provisions:

Signature of Patient/Client **Date**

Signature or Parent, Guardian or Personal Representative **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.).

Patient/Client Refuses to Acknowledge Receipt:

Signature of Staff Member Date

The Kennedy Center for Counseling

Cancelation Policy

I verify that I understand the following:

CREDIT CARD REQUIRED- **All patients** are required to keep a current valid credit card on file with us at all times. In the event you fail to give our office 24 hour cancellation notice, your credit card will be charged with a fee of $50.00. The Kennedy Center may also charge your credit card if your account balance is delinquent for any outstanding balances not paid within 2 billing periods after receiving. _____ **Initial**

CANCELLING APPOINTMENT- We ask every patient to be courteous and respectful of others needs and therefore, we require at least a 24 hour notice in canceling your appointment. _____ **Initial**

INSURANCE DOES NOT COVER LATE CANCEL NO SHOW APPOINTMENTS

IF YOU HAVE A FAMILY EMERGENCY- BRING A COPY OF YOUR ER VISIT OR URGENT CARE VISIT TO YOUR NEXT APPOINTMENT SO THE FEE MAY BE WAIVED.

Payment at time of service is expected unless other arrangements have been made.
_____ **Initial**

Health insurance If health insurance covers my sessions, The Kennedy Center for Counseling will help me seek reimbursement from the insurance company. **ANY** unpaid balance after insurance is **MY** responsibility to pay. I agree that The Kennedy Center may release to my insurance company any information needed to secure payment for service. _____ **Initial**

Unpaid account balances If I do not pay my account balance after receiving two notices of the delinquency, I understand that my account may be charged to my credit card or turned over to collections. _____ **Initial**

Insufficient funds In the event that any check I write is returned NSF (insufficient funds) I agree to pay a $15.00 Service Fee. _____ **Initial**

I understand and agree to the above provisions

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative **Date**

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual

_____

Signature of Staff Member Date

Authorization To Use Credit Card

I authorize The Kennedy Center for Counseling, P.C. to keep my signature on file and to charge my credit, debit, CareCredit, or HSA Card for:

We do not accept American Express

____ Monthly balance of charges due by patient and/or guarantor.

____ Recurring charges weekly for required co-payments.

I understand that this form is valid only during the terms of my treatment services at The Kennedy Center.

Patient Name: _____

Credit Cardholder Name and Address:

_____

_____

_____

Credit Card Account Number: _____ -_____-_____ -_____

Card Expiration Date: _____/_____

Printed Name of Cardholder:

_____

Cardholder's Signature: _____

Date: _____

INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about our decision (yours and mine) to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between us.

Decision to Meet Face-to-Face

We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services

You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure (Please initial each highlighted space)

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, office staff and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.

Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, I won't charge you our normal cancellation fee. __
- You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. ___
- You will wear a mask in all common areas of the office (I and others will too). ___
- You will keep 6-foot distance and there will be no physical contact (e.g. no shaking hands) with me or office staff. ___
- You will not bring anyone else to the office that is not participating in a session. ___
- If you have a job that exposes you to other people who are infected, you will immediately let therapist and office staff know. ___
- If a resident of your home tests positive for the infection, you will immediately let me and office staff know and we will then begin / resume treatment via telehealth. ___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure
My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts on our website and in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick
You understand that I am committed to keeping you, me, office staff and all our families safe from the spread of this virus. If you show up for an appointment and I or office staff believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I or office staff test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, the practice may be required to notify local health authorities that you have been in the office. If we have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient/Client Date

_____ _____
Therapist Date