Client Registration/Personal Information/Financial Obligation Form/Informed Consent
Lori Andrews, LCPC
1105 Curtiss Street, Downers Grove, IL 60515
630.968.9817

Please print and complete all areas of this form provide a copy of your Insurance Card, front and back.

Date _____

Client Registration

*Name_____Date of Birth_____Occupation_____

Address_____City_____St_____Zip_____

Home Phone_____Cell Phone_____Email_____

*If Client is minor, Parent/ Guardian Name_____

Marital/Relationship Status_____ How long? _____ Spouse DOB _____

Children/Ages/Names_____

How were you referred? _____Emergency Contact_____

Primary Insurance and Policy Holder (We do not accept secondary plans)
Insurance Co. Name _____ Ins. Phone # _____

Ins. Claims Address _____ Insurance Type (HMO,PPO)_____

Providing Employer _____ Authorization or Referral Req'd? ____

Insured Name _____ DOB _____ ID#_____Group #_____
** Note that signing this form you are assigning benefits to the provider**

Does EAP Apply? _____ If yes, how many visits allowed through EAP? _____

EAP Claims submitted to? (Name, Address, Phone) _____

Personal Information

Medical History:
Illnesses _____

Medications_____

Previous Surgeries_____

Have you ever sought counseling in the past? Y N
If yes, when? _____ With whom? _____

In your own words please describe your reason/s for seeking counseling at this time:

Personal Information Continued:

Tobacco Use Y/N_____ Alcohol Use Per Day_____ Week_____

Have you ever used drugs Y/N_____Currently Y/N_____ If Yes, What type and length of use_____

Do you have any concerns about Substance use? _____
Current Problems (Check appropriate ones)

__Headaches	__Alcoholism/Addiction	__Overwhelmed
__Dizziness	__Feeling tense	__Shyness
__Fainting spells	__Feel panicky	__Can't make decisions
__Fast heart beat	__Hands shaking	__Lonely
__Stomach issues	__Depressed	__Job dissatisfaction
__Bowel issues	__Feeling inferior	__Drugs
__Tiredness	__Cannot relax	__Trouble sleeping
__Sexual issues	__In-law issues	__Financial issues
__Lack of concentration	__Home conditions	__Vision problems
__Hearing problems	__Eating concerns	__Weight loss or gain

The information above is accurate as of this date _____. I understand that if my insurance information changes it is my responsibility to inform this office immediately.

Signature_____

Financial Obligation/Policy

I am committed to your treatment being successful. Please understand that payment of your bill is considered to be your obligation in exchange for me providing you or your family with services. The following is a statement of my Financial Policy which I require you to read and sign prior to any treatment. Note that I accept cash, checks and credits cards as forms of payment.

Regarding Insurance and Payments

Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. For insurance plans in which I am a participating provider your claim will be processed as a service to you. All co-pays will be required at the time of service. In the event that you do not have insurance or are a member of a plan that I do not participate in, full payment is due at the time of service. I will provide you with a paid invoice receipt that you can use to place a claim.

Missed appointments

If cancellation is necessary, the patient needs to notify the office at least 24 hours before the appointment time. I hold this appointment time open specifically for you so it is in courtesy to other patients who need appointment times that you call me in a given time frame. These types of charges are not billable to insurance companies, as they are not covered. ***All clients are required to have a valid credit card on file in order to receive services. **A $25 fee will be added if your card is declined*****
The card on file will be used for deductibles, copays, coinsurance or arranged fees.
Do you agree to have us use your card for ongoing charges? Yes_____ No_____

Thank you for understanding our financial policy. Please let me know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy. By signing, you acknowledge that you understand this information and agree to these terms.

Signature_____ Client Name_____ Name on Credit Card_____

Credit Card Number_____ Exp. Date_____ Security Code _____

<u>For Provider Use Only</u>

Diagnosis

Code(s)_____ Patient Informed Consent Reviewed and Attached Y/N_____

Informed Consent for Treatment

1. I hereby consent to receive counseling services from Lori Andrews, LCPC
2. I realize that no particular outcome/result can be guaranteed as a result of my consent to treatment.
3. I hereby release Lori Andrews LCPC from responsibility for any injury that results from my leaving services against clinical and/or medical advice.
4. Your treatment is confidential within the limits prescribed by law. If you choose to contact me by email or text, it is important to know that confidentiality through these sources of communication cannot be guaranteed. In general, no information about your treatment will be released without your written consent. However, relevant laws require that your therapist contact others about your safety in the following situations: you are assessed as presenting a danger to yourself or others or harm being caused to a minor, disabled or elderly.
5. Lori Andrews complies with all HIPAA regulations. Policies and Procedures manual available for review upon request.

If you (client) are under 12 years of age, your therapist may discuss your treatment with your parent or legal guardian. If you are over 12 years of age and under 18 years of age, your therapist may discuss your treatment with your parent or legal guardian with your consent. If you are engaging in behavior that your therapist believes places you in danger of significantly harming yourself or others, your therapist will help you to discuss these issues with your parents.

I certify that I have fully read and understand the above consent and information and have had opportunity to ask clarifying questions and agree with the content of this consent form.

Client/Legal Guardian: _____ Date: _____

Physician Consent

I hereby give my consent to inform and/or discuss my condition with my physician of choice. I also consent to release any medical documentation for purposes of treatment. Please include physician contact information:
Name _____ Phone _____
Address _____

Client/Legal Guardian:_____ Date: _____

Communication Consent

If you would like your medical information released to someone other than yourself, please complete the following:
I authorize Lori Andrews LCPC to leave information pertaining to my care by the following methods and will assume responsibility to notify if this information changes.
Home Telephone Y/N____ Cell Phone Y/N ____
Please list any additional individuals, relationship to you and phone for those are authorized to discuss your care:

_____

Client/Legal Guardian: _____ Date: _____