Lotus Integrative Behavioral Health

1905 Marketview Dr, #256,
Yorkville, IL 60560

CLIENT INFORMATION

Patient Name: _____

Street Address: _____

City, State, Zip: _____

Date of Birth: _____ SSN: _____

Gender: _____ Marital Status: _____

Work Status: ☐ Employed ☐ Unemployed ☐ FT Student ☐ PT Student

Employer/School & Address: _____

_____

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Home Phone: _____ May we leave a message? Y N

Work Phone: _____ May we leave a message? Y N

Cell Phone: _____ May we leave a message? Y N

Other attending family members: _____

Others you wish to have access to your appointment schedules, and/or billing information (If you elect this option, we will provide releases that describe the limits of information to be released).

Home Phone: _____ Phone: _____

Home Phone: _____ Phone: _____

REFERRAL INFORMATION

How did you hear about us? (Circle One): Friend Professional Internet Other

Referred by: _____

Address: _____

Phone Number: _____

PRIMARY CARE PHYSICIAN INFORMATION

PCP Name: _____

PCP Address: _____

Phone Number: _____

INSURANCE INFORMATION

Insured's Name & Address: _____

_____

Home Phone: _____ Date of Birth: _____

Work Phone: _____ SSN: _____

No need to complete if you have an insurance card we can photocopy.

Ins. Company Name: _____

Claims Address: _____

City, State, Zip: _____

Member ID#: _____ Policy/Group #: _____

Plan Name #: _____ Reference #: _____

For office use only DSM: Authorization #:

Client's Name: _____ Date: _____

Person completing form: _____

Please check how often these symptoms occurred *in the last six months.* **If you are a parent completing this form for your child/adolescent, please provide your child's/adolescent's symptoms** *in the last six months*.

Area of Concern	Never	Several Days	More than half the days	Nearly every day	Area of Concern	Never	Several Days	More than half the days	Nearly every day
Absences from School/Work					Thinking About Death				
Addictions					Thinking About Suicide				
Aggression					Hopelessness				
Agitation					Loss of Interest in Activities/Relationships				
Alcohol Use					Memory Loss				
Anger					Mood Changes (sudden)				
Anxiety					Muscle Tension				
Blackouts					Nightmares				
Chest Pains					Panic				
Compulsive Behaviors					Perfectionism				
Concentration Difficulties					Physical Abuse (past/current)				
Conflict at Work/School/Home					Poor or No Appetite				
Crying Excessively					Pornography				
Overly Distracted					Problems At Home				
Feeling Down and/or Sad					Problems Falling Asleep				
Illicit Drug Use					Problems Staying Asleep				
Low Energy					Problems w/ Family Members				
Too Much Energy					Racing/Intrusive Thoughts				
Fatigue					Restlessness				
Fear of Leaving Home					Poor Self-Confidence				
Feeling Anxious and/or Panicky					Self Injury				
Feelings of Guilt					Sexual Abuse (past/current)				
Feeling Jealous					Sexual Dysfunction				
Feeling Worthless					Sexual Orientation				
Food and/or Body Preoccupation					Shortness of Breath				
Gastrointestinal Issues					Sleeping Too Much/Too Little				
Gender Identity/Confusion					Stealing Behavior				
Grief/Loss					Easily Startled				
Hearing Voices					Struggles w/ Social Interactions				
Rapid Heartbeat					Tobacco Use - cig/e-cig/vaping?				
Hallucinations					Under Eating/Restricting Food				
History of Trauma					Vomiting				
Irritability					Weight Loss/Gain				

Other concerns you would like to discuss: _____

_____

Consent to Treatment Form

1905 Marketview Dr, #256,
Yorkville, IL 60560

I consent to take part in the treatment at Lotus Integrative Behavioral Health. I have received and read the **Intake Information** form explaining the risks and benefits of treatment, the fees for services, other policies, and agree to its terms.

I have received and read the **Privacy Notice** as required by the Health Insurance Portability and Accountability Act. I will ask for explanation and clarification of any part of the Intake Information or Privacy Notice that I do not understand.

I understand that **I am responsible for my bill**. While Lotus Integrative Behavioral Health will assist me in pursuing insurance or EAP reimbursement, I understand that unpaid bills will become my responsibility and that failure to make payment within 60 days may result in turning my account over to a collection agency. I understand that Lotus Integrative Behavioral Health may elect to end treatment if timely payment for services is not made.

I understand that I will be charged $140 for failing to show or for failing to give at least **24 hours' notice when canceling an appointment**. I understand that insurance companies and EAPs cannot be billed for this fee and therefore this fee will be my responsibility.

If I am electing to use my insurance or EAP benefits, I authorize release of the necessary information to my insurance company or EAP so that Lotus Integrative Behavioral Health, acting as my agent, may pursue payment for the services provided to me. I authorize insurance or EAP payments to be sent directly to Lotus Integrative Behavioral Health.

Client Signature	Date
Parent/Guardian Signature (if client is between 12 and 18 years old)	Date
Other Family Member	Date
Other Family Member	Date

MEDICATION LIST

Client Name: _____ Date: _____

Current Prescriptions:

Medication:	Dosage:	Frequency:	Route of Administration:

Lotus Integrative Behavioral Health

Credit Card Authorization

I hereby authorize Lotus Integrative Behavioral Health to keep my credit card on file and use for payment of balances owed.

Cardholder Name: _____

Billing Address: _____

_____

_____

Credit Card Type: ____ Visa ____ MasterCard ____ Discover ____ AmEx

Credit Card Number: _____

Expiration Date: _____

CVV Security Code (3-digit code on back of card): _____

Signed: _____

Dated: _____

Printed Name: _____

This authorization can be revoked at any time.

Lotus Integrative Behavioral Health

Notification of Desirability of Conferring with Primary Care Physician

If you agree to waive this notification, Illinois law requires your therapist to notify your Primary Care Physician, if you have one, that you are seeking or receiving mental health services. We believe that it is desirable for us to confer and work together with your primary care physician on your care. By signing this form, you are indicating you do **not** want us to contact your primary care physician.

☐ **I waive** notification to my primary care physician that I am seeking mental health services and I direct you not to notify him/her.

Client's Signature	Date
Parent or Guardian's Signature	Date
Therapist's Signature & Credentials	Date

Lotus Integrative Behavioral Health

Consent for Release of Information

Lotus Integrative Behavioral Health

1905 Marketview Dr, #256,
Yorkville, IL 60560

I, _____,
Client Name Date of Birth SSN

request and authorize Lotus Integrative Behavioral Health to

☐ Exchange with ☐ Receive from ☐ Provide to

_____
Name and Address of Agency or Person to Provide or Receive Information

information (in written and/or oral form regarding:

- ☐ Initial Evaluation and Recommendations
- ☐ Treatment Summary
- ☐ Psychological Evaluation
- ☐ Social History
- ☐ Progress Notes
- ☐ Duration of Treatment or Program
- ☐ Summary of Treatment or Program
- ☐ Coordination of Care
- ☐ Medical History
- ☐ Diagnosis and Assessment
- ☐ Physician Notification
- ☐ Hospital Discharge Summary
- ☐ Academic Performance
- ☐ Social Skills and Behavior at School
- ☐ Appointment Times/Attendance
- ☐ Financial/Insurance Information

This information is for the purpose of:

- ☐ Assisting with the client's evaluation and treatment
- ☐ Coordinating Services between Lotus Integrative Behavioral Health and agency or person named above
- ☐ Transferring information regarding previous treatment
- ☐ Planning and implementing therapy for the client and/or client family
- ☐ Determining if Lotus Integrative Behavioral Health services are appropriate for the client's needs
- ☐ _____

I understand that this consent will automatically expire on _____ 20____

The consequences of a refusal to release the information itemized above may be the inability to:

- ☐ Provide continuity and/or coordination of care
- ☐ Develop a comprehensive assessment and treatment plan
- ☐ Other: _____

I authorize you to send/receive copies of these records or reports to/from Lotus Integrative Behavioral Health at the address shown on this form.

I understand that my clinical record may contain psychiatric, mental health, developmental disabilities, alcohol and/or drug abuse information and/or Acquired Immune Deficiency Syndrome (AIDS) and/or HIV test results and information.

I authorize the release of information itemized above solely for the purpose itemized on this consent form. Only such information and/or records believed necessary for the purpose expressed above shall be released and disclosed. I may inspect and copy the information to be disclosed.

I understand that I have the right to revoke this consent at any time. The revocation must be in writing and received by the person releasing the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.

I understand that the infromation received cannot again be given to any other agency or person without my written consent.

I understand that I do not have to sign this authorization and Lotus Integrative Behavioral Health may not condition treatment on whether I sign this authorization.

_____
Client Signature Date

_____
Parent/Guardian Signature (if client is between 12 and 18 years old) Date

_____
Lotus Integrative Behavioral Health Staff Signature/Witness Date

Email/Text Agreement

I understand that email and text messaging offer an easy and convenient way for clients and therapists to communicate with one another. In many circumstances, such as for confirming or cancelling appointments, these forms of communication have advantages over telephone calls. However, I would like to inform you of some important disadvantages as well.

In many circumstances, text messages appear on computers in addition to phones. The latest HIPAA rules consider any information/communication associated with your treatment at Lotus Integrative Behavioral Health, LLC as Protected Health Information (PHI). I cannot guarantee the security of unencrypted electronic communications. This means that email and/or text messages are not confidential.

Therefore, emails and/or text messages should not be used to communicate sensitive health information, which may include mental health and substance abuse details. In some circumstances, your email and/or text messages may become part of your health record. Finally, email and/or text messaging is not a substitute for seeing your therapist. If you think you need to be seen, please call and schedule an appointment.

With this in mind, I still consider emails and/or text messaging to be an acceptable part of communication with my clients. However, to use it with you, I need to document that you have been informed of the risks involved in using email and/or text message communication related to your PHI and have secured your consent to send and receive emails and/or text messages with Lotus Integrative Behavioral Health, LLC.

Client Name: _____

Email Address: _____

Cell Number: _____

The email address and/or mobile phone number provided above are authorized for the purpose of receiving and responding to email and/or text communication. These will be the only ones used for purposes of email and/or text communication. Should either the email address or mobile phone change, please notify Lotus Integrative Behavioral Health, LLC as soon as possible with an update.

Client Signature:

_____

Date: _____

Therapist Signature:

_____

Date: _____

Notice of Privacy Practices

Lotus Integrative Behavioral Health is committed to treating and using your protected health information responsibly and every effort is made to keep your personal health information private. This notice describes the procedures we use to protect your information, and the circumstances under which your personal health information may be disclosed. It also describes your rights as they relate to this information. The rules for confidentiality of mental records are recorded in the Illinois Mental Health and Developmental Disabilities Confidentiality Act and in the privacy rules or the Health Insurance Portability and Accountability Act (HIPAA). Please review this carefully to understand our procedures and your rights. If you have any concerns about your privacy, please discuss them with your therapist.

You are entitled to a copy or review of your mental health records.

You have the right to inspect and/or copy your health record. Emails that include clinical information may be included as part of the record. If, after reviewing your record, you believe that any statement is in error, you have a right to request the person who made the entry make a correction. Anytime you request a revision, your request and the action taken must be noted in the record. If a professional chooses to stand by a statement with which you disagree, you have the right to add a written amendment stating why you believe the entry is in error. Any time that section of the record is released, your amendment must be included.

The following individuals can access a mental health record without written authorization.

1) an adult recipient of services; 2) the parent or guardian of a child who is under 12 years of age; 3) the recipient if he/she is 12 years of age or older; 4) the parent or guardian of a recipient who is at least 12 years old, but under 18 years old, if the recipient does not object or if the therapist does not find a compelling reason for denying access, but nothing in this statement is intended to prevent a parent or guardian of a child who is at least 12, but under 18, from requesting and receiving the following information: current physical and mental condition, diagnosis, treatment needs, services provided, and services needed; 5) a legal guardian of a recipient who is 18 or over; 6) an attorney, guardian ad litem, or power of attorney or other person who is legally authorized to access the records. Your therapist is happy to provide you with assistance in understanding the record.

In the following circumstances, we may release your records without your permission.

There are circumstances that impose limitations on a client's right or ability to maintain privileged communication. A therapist may disclose a record without consent: 1) to a supervisor, consulting therapist, or member of the staff team participating in the provision of services, a record custodian, or a person acting under the supervision of the therapist; 2) when a therapist believes a clear and immediate danger exists to one or more persons; 3) when disclosure is necessary to provide a recipient with emergency medical care or access to needed benefits when the recipient is not in a condition towaive or assert his or her rights; 4) when abuse or neglect of a child is suspected; 5) when a therapist is consulting with an employer, attorney, professional liability company, or other relevant business associate concerning the care or treatment he orshe has provided, including disclosure to business associates who may help us pursue payment (but each of these recipients shall be held to HIPAA privacy standards and may not redisclose the information); 6) when a recipient introduces his or her mental condition or any aspect of services received for such condition as an element or a claim or defense; and, 7) in certain other legal situations where the court has decided that disclosure is directly relevant to the issue being investigated. Furthermore, as part of the Illinois Firearm Concealed and Carry Act (PA98-063), clinicians are required to notify the Illinois Department of Human Services of anyone who is determined to be a "clear and present danger" to themselves or others or determined to be developmentallyor intellectually disabled.

Additional rights.

You have the right to request restrictions on certain uses and disclosure of personal health information. However, Lotus Integrative Behavioral Health is not required to agree to a requested restriction, and in some situations, is prohibited by law from agreeing to a requested restriction. You have the right to request and receive accounting of disclosures that we make to other individuals.

If you believe your privacy has been violated, first bring the matter to your therapist's attention. If you have a dispute that cannot be resolved, you may also file a complaint with the Office for Civil Rights, U.S. Dept of Health & Human Services, 200 Independence Ave; S.W., Room 509F, HHH Building, Washington, DC 20201. There can be no retaliation for filing a complaint.

Informed Consent

As with any treatment, there are risks and benefits with therapy. Although most people who engage in therapeutic services report benefits from the process, there are also risks to consider. Risks sometimes include experiencing uncomfortable or painful emotions such as sadness, anxiety, anger, frustration, pain, and guilt, which may be expected as people work to facilitate change in their lives. As you consider these risks, it is also necessary to acknowledge the benefits, which may include increased self-awareness and self-worth, improved relationships and coping skills, stress reduction, as well as the sense of accomplishment experienced when meeting personal goals.

Individuals, couples, and families may discover the counseling process takes them to a place of making important life decisions. While your therapist will honor and respect your right to make decisions for yourself, important people in your life may not agree with a direction you decide to pursue. These experiences are likely to produce new opportunities, as well as unique challenges.

Lotus Integrative Behavioral Health believes that psychotherapy is a collaborative process between the client and therapist. If you have any questions or concerns about your treatment please feel free to discuss them with your therapist.

Protected Health Information and Confidentiality:

The laws and standards of my profession require that I keep and use protected health information in a manner consistent with the rules for confidentiality of mental health records – recorded in the Illinois Mental Health and Developmental Disabilities Confidentiality Act and in the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA). You have the right to inspect and/or receive a copy your health record or a summary can be prepared for you. It is recommended that you review your records in the presence of your therapist to address any questions and/or discuss the contents. Clients will be charged an appropriate fee related to responding to information requests. If, after reviewing the record, you believe that any statement is in error, you have the right to add a written amendment stating why an entry is in error and it will be included in your health records. Anytime that section of your record is released, the amendment must be included.

The law protects the privacy of all communications between therapist and client and protected health information may only be released with your written permission. There are, however, exceptions to confidentiality. Protected Health Information may be released without consent when 1) a therapist is disclosing information to a supervisor, consulting therapist, and/or member of treatment team participating in the provision of services, a record custodian, or a person acting under the supervision of the therapist;

2) when a therapist believes there is a clear and immediate present danger to one or more persons; 3) when disclosure is necessary to provide a recipient with emergency medical care or access to needed benefits when the recipient is not in a condition to waive or assert his or her rights; 4) when abuse or neglect of a child is suspected; 5) when a therapist is consulting with an employer, attorney, professional liability company, or other relevant business associate concerning the care or treatment he or she has provided, including disclosure to business associates who may help us pursue payment (but each of these recipients shall be held to HIPAA privacy standards and may not re-disclose the information); 6) when a recipient introduces his or her mental condition or any aspect of services received for such condition as an element of a claim or defense; and, 7) in certain other legal situations where the court has decided that disclosure is directly relevant to the issue being investigated. Furthermore, as part of the Illinois Firearm Concealed and Carry Act (PA98-063), clinicians are required to notify the Illinois Department of Human Services of anyone who is determined to be a "clear and present danger" to themselves or others or determined to be developmentally or intellectually disabled. Please ask if you have any questions and/or concerns about confidentiality.

Appointments and Cancellations:

Therapy appointments range from 45-60 minutes in duration and typically occur on a weekly or bi- weekly basis. Duration and frequency vary depending on your individual needs. If you need to cancel your appointment, please notify me at least 24 hours in advance of your reserved appointment time. Please understand that because this time is reserved for you, the lack of adequate notice prevents sufficient time to schedule other clients in need. If you do not provide 24 hour notice of a cancellation, you are responsible for paying the full amount of the session. Insurance companies will not cover missed or no-show appointments.

Hours and Availability:

I can be reached at 630-551-8684. You may be prompted to leave a voicemail and your call will be returned within 24-hours, excluding weekends and holidays. If you are experiencing an emergency, please call 911 or go to the nearest hospital emergency room. You can also utilize one of the following crisis lines: DuPage County: 630-627-1700; Will County: 815-722-3344; Kane County: 630-966-9393,; Kendall County; 630-553-1400; Dekalb County: 866-242-0111, call your primary care physician or psychiatrist.

Insurance, Fees and Diagnosis:

Most insurance agreements require your therapist to provide a clinical diagnosis and sometimes clinical information such as treatment plans and progress reports. This information will become part of the insurance company files and may be computerized. All insurance companies claim to keep such information confidential; however, Lotus Integrative Behavioral Health has no control over its use once it is provided to the insurance company. It is important to remember that you always have the right to pay for services directly to avoid the reporting and complexities associated with insurance coverage.

If you will be using health insurance, part of your therapy expenses may be covered. You are responsible for verifying the details of your health insurance policy/ determining your insurance benefits, as well as verifying that your therapist is a covered provider. If fees you expect your insurance company to cover are rejected, you are responsible for the payment unless otherwise agreed in advance. You remain personally responsible for deductibles, co-payments, coinsurance, non-covered, ineligible, or unauthorized services and are expected to pay for services at each session. Acceptable forms of payment include cash, credit/debit card (VISA, MasterCard or Discover, AMEX), or check (payable to Lotus Integrative Behavioral Health, LLC). ***Please remember appointments must be cancelled within 24 hours prior to the appointment time or you will be charged in full.***

There is a $25.00 charge on all returned checks. Returned checks must be replaced with cash, certified check or money order. Delinquent accounts may be referred for collection and credit reporting as well as interest added to balances over 60 days. You are responsible for all attorneys' fees and court costs incurred by Lotus Integrative Behavioral Health in connection with the recovery of unpaid counseling fees.

Based on the services provided, there may be fees charged for other services that can include: report writing, telephone conversations lasting 20 minutes or longer, attendance to meetings with other professionals you have authorized, and the preparation of records or treatment summaries. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for professional time spent even if they are called to testify by another party. Fees for preparation and attendance at any legal proceeding are $250 per hour, including travel time.

Fees reflect specialized training and experience. Unless arranged in advance or dictated by insurance agreements, fees for a typical session are as follows: Initial Evaluation Sessions - $185; Ongoing Individual/Conjoint Psychotherapy Sessions - $160/$140 based on the services provided. There may be fees charged for other services that can include: report writing, telephone conversations lasting 20 minutes or longer, attendance to meetings with other professionals you have authorized, and the preparation of records or treatment summaries. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for professional time spent even if they are called to testify by another party. Fees for preparation and attendance at any legal proceeding are $250 per hour, including travel time.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

CLIENT SIGNATURE _____
(Age 12 or over)

DATE _____

PARENT/GUARDIAN SIGNATURE _____
(for minor child)

DATE _____

Lotus Integrative Behavioral Health