CLIENT INTAKE FORM

Client Name: ____ **Date**:__________________________

Date of Birth: _________________________________**Age**: _________________ **Gender**: ☐Male ☐Female

Client Address: ____

____

City, State, ZIP: ____

Client Marital Status:
☐Single, Never married ☐Separated
☐Married ☐Divorced
☐Domestic Partnership ☐Widowed

Please include area codes		MSG OK?		OK to Text?	
Home Phone:	_________________________	☐YES	☐NO	☐YES	☐NO
Work Phone:	_________________________	☐YES	☐NO	☐YES	☐NO
Client Cell Phone:	_________________________	☐YES	☐NO	☐YES	☐NO
Parent/Guardian Cell Phone: **Name**: ________________	_________________________	☐YES	☐NO	☐YES	☐NO
Parent/Guardian Cell Phone: **Name**: ________________	_________________________	☐YES	☐NO	☐YES	☐NO

Client's Preferred Contact Number: ☐HOME ☐WORK ☐CELL ☐ N/A –Child Client
Parent/Guardian's Preferred Contact Number: ☐HOME ☐WORK ☐CELL

Please list the names of the child client's legal guardian/s. Both biological parents typically remain legal guardians even in the case of divorce. A parent's legal status as guardian can ONLY be altered via court order:

____

Names of client's legal guardian/s

Please list the name, age and relationship of all household members:

Name	Age	Relationship to Client

EMERGENCY CONTACTS (Parents, please at least one contact who is not the child's parent or guardian):

Name: ____________________________Number: _________________________Relationship to Client: _______________

Name: ____________________________Number: _________________________Relationship to Client: _______________

Pertinent Emergency Medical Information (i.e. Asthma, Pregnant, Diabetes, Allergies to specific medications/latex):

Please List: ____ ☐None, No known allergies

CLIENT INTAKE FORM

Household Vehicle Make/Model: ___________________________ **Vehicle License Plate**: _____________________

Household Vehicle Make/Model: ___________________________ **Vehicle License Plate**: _____________________

Have you or anyone in your household ever possessed Firearm Owner Identification Card? ☐Yes ☐No ☐ I don't know

Are there firearms in your/the client's home? ☐Yes ☐No ☐ I don't know

IF YES, Please answer the following:

Do you know where they are kept? ☐Yes ☐No ☐ I don't know ☐Not Applicable
Does your child/children know where they are kept? ☐Yes ☐No ☐ I don't know ☐Not Applicable
Are they kept locked/secured? ☐Yes ☐No ☐ I don't know ☐Not Applicable
Is ammunition stored separately? ☐Yes ☐No ☐ I don't know ☐Not Applicable

Please check if you/your child have difficulty or need assistance with: ☐NOT APPLICABLE/NO CONCERNS

☐Reading ☐Hearing
☐Writing ☐Physical mobility
☐Vision ☐English Language (Native Language: ____________)
☐Speech ☐Other – Please Describe: _____________________

Note: Do not include age-related limitations (i.e. A 2 year old child who cannot read)

Client Employment Status (Check all that apply):

☐Full Time
☐Part Time
☐Employed but on Leave of Absence
☐Unemployed, Seeking work
☐Child client/Not applicable
☐Unemployed, Not seeking work
☐Stay-at-home Parent
☐Retired
☐Disabled/Unable to Work

Type of Industry/Work you have done (Past/Present): ____________________________ ☐Not applicable

Highest Grade Completed in School: ______ **Name of School**: ____

Current Grade/Year in School: ______ ☐Not Currently Enrolled **Student Status**: ☐Full Time ☐Part Time ☐Not Enrolled

Were you encouraged by your employer, supervisor, Human Resources, or EAP to attend counseling? ☐Yes ☐No

Were you encouraged by an attorney, probation or parole officer, child welfare agency, judge, or court order to attend counseling? ☐Yes ☐No

Are the client's current symptoms related to any:

1. Employment (Past or Present) that would involve Workers' Compensation? ☐Yes ☐No
2. Auto Accident? ☐Yes ☐No
3. Other Type of Accident? ☐Yes ☐No
4. Crime or Sexual Assault reported to Law Enforcement? ☐Yes ☐No

***NOTE**: If you have answered 'yes' to any of these four questions, we will discuss any impact or adjustments that may need to be made with regards to financial responsibility.*

CLIENT INTAKE FORM

THE FOLLOWING SECTION IS OPTIONAL:

________PLEASE INITIAL HERE IF YOU DO NOT WISH TO USE ELECTRONIC COMMUNICATIONS

CONSENT REGARDING ELECTRONIC COMMUNICATIONS: Electronic communications are provided as a convenience, and are in no way a requirement or necessity for your participation in services. If you opt to use email, Skype, or texting with your clinician, confidentiality and security can **NOT** be guaranteed. Communication via electronic means is not reimbursable by managed care services, and you may incur self-pay charges as a result of contact with your therapist in this matter. Use of technology is AT YOUR OWN RISK. **All communications received to/from Insight Therapeutics, Inc. are included in the written clinical record of the client**.

Client Email Address: ____

Client Signature (Age 12 and older):______________________________Date of Signature: ______________

☐ Client is under age 12 at time of signature. Date client will turn age 12: ______________________

Parent/Guardian Email Address:____

Parent/Guardian Signature):______________________________Date of Signature: ______________

Parent/Guardian Email Address: ____

Parent/Guardian Signature):______________________________Date of Signature: ______________

THIS SECTION BELOW APPLIES TO CHILD AND ADOLESCENT CLIENTS ONLY:

For clients under 18, Names of Legal Guardian(s): ______________________________________

Marital status of client's legal guardians:

☐Not currently together, Never married

☐Married

☐Domestic Partnership

☐Separated (Month/Year of Separation: ______________________)

☐Divorced (Month/Year of Divorce: ______________________)

☐Second Parent/Guardian Deceased (Month/Year: ______________________)

If parents or guardians are separated or divorced, please describe the custody/living arrangement of the client at this time:

____

Have you discussed with the child's other parent or guardian that you have sought mental health care for the client?

☐Yes If Yes, are they in agreement with the client receiving treatment? ☐Yes ☐No
☐No If No, please provide reason: ______________________________________
☐ I am unable to locate or contact him/her.
☐Other (Describe): ______________________________
☐Not Applicable

INFORMED CONSENT FOR TREATMENT

Please carefully review the following statements:

1. I **have received (either digitally or in person), read, and understood the following forms from Insight Therapeutics, Inc.**:
   - Client Rights and Responsibilities (1 page)
   - Financial Policy (1 page)
   - Notice of Privacy Practices ("Your Information. Your Rights. Our Responsibilities.") (5 pages)

2. **To the best of my knowledge, I have provided accurate and complete information on the following forms for Insight Therapeutics, Inc.:**
   - Client Intake (includes Consent for Electronic Communications) (3 pages total)
   - Insurance Information and Consent (1 page)
   - Payment Information Form (1 page)
   - Informed Consent for Treatment (1 page)
   - *Certification of Authority if applicable (Staff Initial and Date* _______________ ☐Reviewed with Guardian*)*

3. **I have provided all necessary information pertaining to billing and payment for services including:**
   - Copy of my health insurance card (Staff initial and Date _______________________)
   - *EAP/Insurance Authorization information if applicable (Staff initial and Date _________________)*

Having fully reviewed and agreed to all of the information noted above, I voluntarily consent to mental health treatment for myself and/or my child/dependent and understand that I am responsible for notifying Insight Therapeutics, Inc. of any changes to this information as soon as possible. I understand that if I have any questions or concerns regarding these policies, I can discuss them with my clinician at any time.

Client Signature (Age 12 and older):____Date of Signature: __________________

☐ Client is under age 12 at time of signature. Date client will turn age 12: ____

Parent/Guardian Signature: ____Date of Signature: _________________

Parent/Guardian Signature: ____Date of Signature: _________________

Relationship of Parent/Guardian (Check one):
☐ Biological or Adoptive Parent
☐ Legal Guardian
☐ Power of Attorney
☐ DCFS Authorized Agent
☐ Other: ____

Staff Signature: ____Date of Signature: _________________

Clinical Director Signature: ____Date of Signature: _________________

INSURANCE INFORMATION AND CONSENT

PLEASE INITIAL HERE IF YOU DO NOT HAVE OR DO NOT WISH TO UTILIZE INSURANCE: ________

PRIMARY INSURANCE INFORMATION

Client Name: ___________________________________ DOB:_____________________

Insured Name: _________________________________ DOB:_____________________

Insured Party's Contact Information (If different from client): ☐ Same as client

Street: ____

City, State, ZIP: ____

Insured Party School/Employer (Source of Insurance):___________________________________

Insurance Company Name:____

Insurance Policy Type: ☐HMO ☐PPO ☐POS ☐Unknown ☐Other: _________________________

Insurance ID Number (from card): ____

Insurance Group Number (from card):_______________________________________

Insurance Customer Service Phone Number: ___________________________________

PLEASE INITIAL HERE IF YOU HAVE A SECONDARY INSURANCE POLICY YOU WISH TO USE: ________

☐ **PLEASE PROVIDE YOUR INSURANCE CARD (OR A COPY) TO YOUR CLINICIAN.**

INFORMED CONSENT REGARDING USE OF HEALTH INSURANCE:

Insight Therapeutics, Inc. strives to make therapy services affordable and accessible. Use of managed care of health insurance is a financial contract between an insured member and the insurance company. We will do our best to help you utilize your insurance benefits; however financial responsibility lies with the client (or parent/guardian in the case of minor or dependent clients). In accordance with Insight Therapeutics' Privacy Practices and Financial Policies, I authorize Insight Therapeutics to provide all necessary information to my managed care company and/or insurance company needed to process claims. **I understand that a diagnosis may be required to utilize health insurance, and that my insurance policy may have varying procedures or limitations in coverage depending on diagnosis rendered**. I understand that some services may **NOT** be reimbursed or covered by health insurance, and that I am ultimately financially responsible for all charges incurred. **I understand that I am required to furnish Insight Therapeutics, Inc. with information regarding changes in my health insurance status or eligibility as soon as they occur.**

SPECIAL NOTE REGARDING DEPENDENT CARE AND INSURANCE CONFIDENTIALITY:

Please note that if your health insurance is provided by someone other than yourself (for example a spouse, ex-spouse, parent who does not live with you, other third party) they may receive information about treatment services provided. Typically, an insurance company's Explanation of Benefits form (EOB) provides information about the date/location of service, name of provider, billing code, and diagnosis code. You will need to contact your insurance company directly if you do not want this information sent to the insurance policy holder. Insight Therapeutics has no ability to impact how your insurance company may share billing or use of benefit information. Additionally, being a policy holder does **NOT** entitle someone to confidential information about treatment, and is **NOT** the same as being able to consent to treatment. If a policy holder contacts Insight regarding services rendered, a signed release of information will be required by the client to provide further information. If you have questions or concerns about this, please discuss this with your clinician.

My signature below indicates I have read and understand the Financial Policy and Informed Consent Regarding Insurance:

Client Signature (Age 12 and older):____

Parent/Guardian Signature: ____

PAYMENT INFORMATION FORM

Insight Therapeutics, Inc. offers credit/debit card payment processing through Square, an encrypted mobile card reader system that is integrated with the billing system for Insight Therapeutics, Inc. Square houses payment data on servers with a minimum of 128-bit encrypted security keys with extended validation SSL certificates. While your provider may swipe your credit card on what appears to be their personal cell phone, tablet or computer, you can rest assured that **NO CARD INFORMATION IS STORED ON THE PHYSICAL DEVICE USED FOR PAYMENT**. Instead, payment data is stored on Square's servers, an account that is only accessible to Insight's billing staff. If you would like more information about Square and their security policies, please review their website at www.squareup.com.

If you have the same debit/credit card, Flexible Spending Account (FSA), or Health Savings Account (HSA) card you would like to use for payment of services, you are welcome to keep this information on file with Insight Therapeutics, Inc. This prevents you from having to remember to bring a specific card or your checkbook to each session, and your receipts for payment can be electronically sent to you. This also prevents our staff from having to reserve a portion of your appointment time to settle your account each session. This form is kept as part of your client billing file and will NEVER be released to a third party unless we are legally obligated to do so. If you opt to bill payments for an appointment to a credit card number on file, your clinician will write "CC on File" on your super bill. **We assume that the funds are available on the stored card that day unless you tell us otherwise**. If they are not, your clinician will contact you to alert you that the card has been declined. We ask that you then make prompt payment arrangements with your therapist. Please note that missed appointment fees are NOT able to be paid with an HSA or FSA card. **Charges that may be reversed or declined by the credit card company for any reason remain the responsibility of the client/guarantor for payment**.

Card Company (Check one): ☐Visa ☐MasterCard ☐Discover ☐American Express

Card Type (Check one): ☐Credit ☐Debit ☐Health Savings Account (HSA) ☐Flexible Spending Account (FSA)

Name on Card (Print Clearly):____

Card Billing Address:____

City: _______________________________ **State**: _______ **ZIP**:_______________

Card Number:____

Card Expiration Date: _______________ **Card CCV Code** __________(3 digit number on back of card. For American Express, 4 digit number above the card number on front)

RECEIPT FORMAT (Check one and complete):

☐Email Receipt to: ___________________________

☐Text Receipt to: ___________________________

☐No digital receipt needed, I will keep the receipt provided at the time of session.

My signature authorizes Insight Therapeutics, Inc. to charge the credit card account listed for services rendered. By signing below, I acknowledge that I am legally able to authorize payments for the above listed credit card. I understand that Insight Therapeutics, Inc. will communicate the amount to be charged prior to charging unless other arrangements have been made. I have read, understand, and agree to the Financial Policy and Payment Information Form for Insight Therapeutics, Inc.

Client Signature (Age 12 and older):____

Parent/Guardian Signature: ____

Insight Therapeutics, Inc.
HEALING FROM WITHIN...

YOUR RIGHTS AS A CLIENT:

- You have the right to be seen at the earliest mutual opportunity.
- You have the right to discuss with your counselor any questions or concerns about the counseling process.
- You have a right to expect confidentiality during the entire counseling process. NO information about you, including whether you are known to this office, will be released to anyone without your consent except as permitted or required by law, including but not limited to the following conditions:
    1. Risk of Harm to self or others (suicidal or homicidal ideation, aggression, violence, or threats of violence). This does NOT include self-injurious behavior unless it is life-threatening.
    2. Reported or suspected abuse or neglect of a child, elderly person, or person with a disability.
    3. If Insight Therapeutics, Inc. or your clinician is served with a court order or subpoena.
    4. If Insight Therapeutics, Inc. and/or your clinician is involved in legal action regarding you or your care.

- Information about you may be shared with another professional for consultation purposes without client identifying information being provided to the consultant. The consultant is also legally required to maintain confidentiality of the information shared.
- You have a right to expect the highest level of commitment from your counselor. You can expect that he or she will maintain professional and ethical standards of care in accordance with their clinical licensure.
- **Emergencies are rare; however, you have a right to expect prompt response at these times. In urgent times, you may reach your counselor by calling (847) 800-9347.**
- You have a right to discuss anything in your counseling records per HIPAA regulations. These records will be maintained for seven years after your last contact (or 7 years after a minor child's 18th birthday) and will be destroyed at that time by shredding or burning.

YOUR RESPONSIBILITIES AS A CLIENT:

- **First and foremost, we can't help if you aren't here**! In working with children, your therapist will discuss with you the recommended frequency of sessions based on their development. Frequently children can't create or maintain change if they forget about therapy between sessions! In making an appointment, you are committing to that time for yourself to the exclusion of others. If you must cancel an appointment, you must provide no less than 24 hours' notice. Failure to cancel in advance will result in charges described in the Financial Policy.
- To gain the most from the therapy process, it's helpful if you are honest about your commitments to self-examination, understanding, and your relationship with your therapist. This includes any concerns you may have regarding services or your clinician. We want to serve you well and appreciate any feedback you may have that will help us to do so.
- Unwise applications of new learning are a common risk in therapy (e.g. being too harsh when learning to assert yourself) as well feeling as though you are regressing when feeling vulnerable. Therapy is a process that is often like taking three steps forward and one step back at times, but the overall momentum should be forward. Talking openly with your clinician about this can help minimize stress about this process.
- You are responsible for maintaining the confidentiality of others that participate in your counseling sessions, such as group therapy or family therapy sessions. In marital therapy, secrets between spouses works against successful outcome; in this regard, *your counselor is not obliged to keep secrets of one spouse from the other spouse.*
- It is best to avoid abrupt terminations from counseling and to honestly discuss, preferably in person or by phone if necessary, the reasons for your desire to terminate. This method can maximize growth and health at these times.

FINANCIAL POLICY

Thank you for choosing Insight Therapeutics, Inc. for you and your family's mental health care needs.

We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of `treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

We accept cash, checks and credit cards (including FSA/HSA/HRA cards) for payment. Payments may be made in person, via mail, or by phone. **Please be aware there will be a $40 charge for checks returned for non-sufficient funds.**

USUAL AND CUSTOMARY RATES

Our fees reflect usual and customary rates for the service area. You are responsible for payment regardless of any managed care's determination of usual and customary rates. You are also responsible for payment of all charges for services rendered regardless of your insurance company's determination of benefits. Phone calls are generally NOT covered by managed care, and billed in 15 minute increments. Frequent email contact with your therapist MAY be billed at the phone call rate at the therapist's discretion, however, for privacy reasons we recommend you contact your clinician by phone instead of email. Video-based therapy services MAY be covered with your managed care plan, but typically have their own limits, rates, and requirements. Your therapist will discuss with you if this is an option how to proceed.

IN NETWORK INSURANCE PLANS

Clients who are members of insurance plans that Insight Therapeutics, Inc. is contracted with (Plans where the practice/your clinician are "in-network" providers) may be required to pay a co-payment, co-insurance, or both at the time of service. Co-payments are typically a predetermined fee (i.e. $20 per session). Please note that mental health benefit coverage is not generally pre-printed on insurance cards. A co-insurance amount is a percentage (i.e. 20% of charges). The amount and type will vary depending on the provisions of your specific policy. These payments are due at the time of service. **You are STRONGLY encouraged to contact your insurance company regarding your plan benefits prior to your first appointment**. If pre-authorization for services is required, it is the client's responsibility to obtain this before beginning services.

OUT OF NETWORK INSURANCE PLANS

Clients who are members of insurance plans where the practice/your clinician is NOT a contracted provider (also known as "out of network" provider) are responsible for payment of full fees at the time of services. We will provide you with a receipt for services (called a "superbill") that contains all the information needed for you to file claims with your insurance company. Not all insurance plans pay the same benefits or apply the same deductible. Since the insurance contract is an agreement between you and your insurance company, any unpaid balance will remain the responsibility of the client (or Guardian in case of minor/dependent clients). After your insurance has notified Insight Therapeutics, Inc. that your deductible has been met and benefits are being applied, only the expected co-payment/co-insurance will be due at the time of service.

MISSED APPOINTMENTS

All appointments must be cancelled or rescheduled with at least 24-hour notice. For your convenience, we provide 24-hour voice mail service and email access to staff for you to meet the time requirement. Please help us serve you better by keeping scheduled appointments. Fees for missed appointments are charged on a graduated basis as follows, REGARDLESS OF WHO IS RESPONSIBLE FOR THE MISSED OR LATE CANCELLED APPOINTMENT. **Insurance does not reimburse for missed appointments**.

1st Missed/Late Cancelled Session	$50.00 Charge
2nd Missed/Late Cancelled Session	$100.00 Charge
3rd and ALL subsequent Missed Sessions	$150.00 Charge per Occurrence

PATIENT BALANCES & COLLECTIONS

Please note that Insight Therapeutics, Inc. does not to allow clients to incur a balance above $200 or go beyond 60 days past due. If your account is in arrears your therapist will assist you in developing a payment plan. **Further sessions will be suspended until account issues are addressed with your clinician**. Exceptions can only be granted by the Clinical Director, and are done so very rarely. Monthly interest (in the amount of 3% per month) will be assessed on accounts over 30 days or those with previous payment arrangements that are not being followed. Accounts with no payment activity will be considered delinquent after 90 days and will be referred to an outside agency for collections.