Living Hope Counseling Center

Adult Client Information

Personal Information			**Acct ID (Office Use Only)**
Legal Name			
Preferred or Nick Name:			
Address			Apt
City		State	Zip
Date of Birth	SEX: M F		
Marital Status: S / M / Wid / Sep / Div	Race / Ethnicity:		
Cell Phone May we text or message you? Y N	Home Phone Message OK? Y N		Other Phone Message OK? Y N
Email Address: *Email is not a secure method of contact. Do you consent to Living Hope sending you emails? Y N*			
Employer and Address			
Are there any special instructions about contacting you at home or work? ______________			

Emergency Contact			
Name			
Address			Apt
City		State	Zip
Cell Phone	Other Phone		
Relationship to Client		SEX: M F	
Email address			
Date of Birth (if Spouse/Partner)	Do you consent to Living Hope contacting this person in an emergency? Y N Initials		

Please list other people in your home:		
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship
Name	Age and DOB	Relationship

History:

How did you hear about Living Hope Counseling Center? ____________________

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? N or Y If yes, previous therapist /practioner ____________________

Current Physician ____________________

Current Medications ____________________

Counseling Goals:

What caused you to begin counseling? ____________________

What do you want to accomplish through counseling? ____________________

Spiritual:

How important is religion or spirituality in your life? ____________________

Do you attend church?	Regularly	Occasionally	Never

Where do you attend? ____________________

CLIENT SIGNATURE ____________________ DATE ____________________

CLIENT FINANCIAL AGREEMENT & POLICY ACKNOWLEDGMENT

Client Name: ____________ Client ID: _______ Date: _______

Please read and initial each item listed below.

____ **Payment of session fees:** Living Hope Counseling Center (LHCC) collects the session fee, insurance copay, coinsurance, deductible amount or other charges at the beginning of the appointment.

____ **Information Change:** It is the client's responsibility to inform providers when information changes including address, phone number and insurance coverage.

____ **Payments Accepted:** Cash, checks, credit, debit, FSA and HSA cards are accepted. A returned check fee charged for all checks returned for any reason.

____ **Reports, Consultations and Court Appearance:** Reports for probation, court, disability, FMLA and letters to physicians, teachers, schools and other requested paperwork are charged according to the current schedule of fees. All reports and court appearance fees must be paid in advance of receipt of report or court appearance. These fees are not typically covered by insurance and will not be billed to your insurance.

____ **Phone Consultation:** You may call your counselor if a crisis arises. **If an emergency is life threatening,** you need to go to the nearest hospital emergency room for a medical evaluation. Your counselor can follow the guidelines and charge for repeated phone call. Phone calls are not typically covered by insurance and will not be billed to your insurance.

____ **Cancelled and Missed Appointments:** If you need to cancel an appointment, please provide notice at least 24 hours prior to the scheduled appointment time to avoid being charged a late cancellation fee. Late cancellations and missed appointments are an automatic $60 fee which will be charged to your credit card on file. (In case of emergency or unprecedented circumstance, the fee can be waived.

____ **Payment of Missed or Cancelled Appointments:** Missed appointments will be charged to a card on file or will be paid by cash or check prior to scheduling another appointment. These fees are the client's responsibility and will not be billed to any third-party paying for the services including insurance, EAP, church partner, etc.

____ **Financial Responsibility:** The client is financially responsible for all charges including the balance remaining after payment of insurance benefits, charges for services not covered by insurance, missed appointment or late cancellation fees, report writing fees, court appearance fees, and any other billing charges deemed appropriate for services rendered. If payments are not made as agreed, your account may be turned over to a collection agency after 60 days delinquency.

____ **Acknowledgement of Receipt of Privacy Notice:** My signature below constitutes my acknowledgement that I have been provided a copy of Living Hope Counseling Center's Notify of Privacy Practices. It describes in detail how my healthcare information is used and shared with others. I understand my rights and responsibilities as related to the Privacy Notice. I understand that Living Hope Counseling Center reserves the right to change the Privacy Notice at any time. I may obtain a current copy of the Privacy Notice by contacting Living Hope Counseling Center's Office at 217-698-7150 (ext. 101) or by visiting the Living Hope Counseling Center website (www.livinghopecounselingcenter.org).

Initial and Complete the following section in regard to your payment method:

____ **Insurance and Assignment of Benefits:** With regards to using an insurance carrier or employee assistance plan (EAP) for counseling services rendered by LHCC, I hereby assign, transfer, and set over to LHCC all of my rights, title and interest to healthcare reimbursement. If payment is received from more than one source causing overpayment for this period of counseling, I authorize application of the overpayment to any unpaid counseling bill for which I am responsible. I hereby authorize LHCC to release to any insurance carrier coded diagnostic and procedural information necessary for the completion of my counseling claim for payment purposes. I release and authorize LHCC to discuss details of my counseling with my insurance carrier and/or designated review agent.

Primary Insurance: ____________________
Policy Holder Name: ______________________ Date of Birth __________

Secondary Insurance (if applicable): ______________
Policy Holder Name: ______________________ Date of Birth__________

(Please present your insurance card(s) to LHCC staff for copying)

____ **Employee Assistance Plan (EAP Authorization)** ____

Authorization or Referral No. __________ #of Sessions___ Expiration Date: ____________

(Please present to LHCC staff for copying any paperwork provided to you by your EAP)

DIRECT PAYMENT METHOD:

_____ I will be paying the standard rate of $150 per 60-minute session.

_____ I will be seeing a student intern and paying $20 per session.

SLIDING SCALE RATES (For clients who do not have insurance. Clients must income-qualify.)

____ I qualify for and will be paying the sliding scale rate of $_____ per 60-minute session. I have provided my required income-verification to LHCC staff for review. If I have not provided the required documentation, I understand that I will pay the full standard rate of $150 per 60-minute session until I have provided the required documentation for review.

____ **PARTNER RATES – CLIENT PAID:** I verify that I attend [partner church] ______________________ and understand I will receive up to six (6) 60-minute sessions paying $60 per session. The $60 per session fee is my responsibility as the client and LHCC will not bill the church for this fee. These 6 sessions will not be billed to insurance. I understand that upon completion of the 6 sessions, if I choose to continue services, I may switch to another payment option available to me. (Client Initials ______)

____ **THIRD PARTY PAID:** [third party name]________________________________ has agreed to pay for ____ 60-minute counseling sessions for me. I acknowledge and grant LHCC permission to provide billing information to the above-name third party representative. I understand that upon completion of the above number of sessions, if I choose to continue services, I may switch to another payment option available to me. (Client Initials ______)

CLIENT SIGNATURE: I acknowledge I have read and understand the above initialed policies, rates and financial responsibilities. I agree to the above terms.

______________________________ ______________
SIGNATURE OF CLIENT DATE

Revised 4/2023

LIVING HOPE COUNSELING CENTER
2200 S. 6th Street, Springfield, IL 62703
(217) 698-7150

Authorization for Credit Card Use

All information will remain confidential.

(This document will be stored electronically, and the paper copy shredded for your protection.)

Client Name: ______________________________

Billing Address: ______________________________

____

I authorize Living Hope Counseling Center to charge the card listed below for copays, deductibles, missed appointments or other charges on account listed on financial agreement.

Cardholder – Please Sign and Date:

Signature: ______________________________

Date: ______________________________

Print Name: ______________________________

Email Address (required for email receipt) ____________________

Credit Card Type: _____ Visa _____ Mastercard ____ Discover _____ AMEX

Credit Card Number: ______________________________

Expiration Date: __________ CVV (3 Digits on Back of Card): ____________

Amount to Charge: $ ____________ (USD) per session.

Office is Authorized to charge card $60 for missed or late canceled appointments.

Revised 8/2023

LIVING HOPE COUNSELING CENTER
2200 S. 6TH STREET, SPRINGFIELD, IL 62703

<u>Informed Consent for Treatment</u>

- I understand that as a part of the healing and growth process, I may experience initial discomfort or worsening of symptoms. This may be as a result of the issues being addressed in counseling.
- I understand not all people benefit from counseling.
- I understand if I do not pay for services as agreed, further services will be suspended until my account has been brought current.
- I understand that Living Hope Counseling Center does not have an answering service. Clients may leave a confidential voicemail message for their counselor at the Center or may call the counselor's after-hours number and calls will be returned within 24 hours or the next business day.
- I understand there will be times my counselor is out of town. During that time emergency calls will be covered by another counselor on staff.
- I understand if my counselor cannot be reached, it is my responsibility to seek another resource by calling 911 or go to the nearest emergency room for assistance.
- I understand I have the right to know my treatment goals, short-term objectives and therapeutic interventions.
- I understand I may choose to decline certain therapeutic interventions.
- I understand that by choosing Living Hope Counseling Center, pastoral counseling may be offered with other counseling techniques; however, these techniques are only provided with my permission. This may include spiritual development & formation, principles/disciplines, biblical teachings, the use of scripture, and prayer.
- I understand no audio or video recordings will be made of my sessions unless I grant permission in writing.
- I understand my counselor meets the requirements of the Illinois State Department of Regulations. My counselor is not a physician/medical doctor and does not practice medicine. If medical treatment or medicine is required, my counselor will recommend I see a physician. My counselor takes no responsibility for services provided by other professionals.
- I understand that I have the right to end counseling at any time without moral or legal obligation.
- I understand my counselor reserves the right to end counseling at any time. Referrals to another counselor will be made at that time, if requested by the client.

<u>Statement of Confidentiality</u>

Confidentiality is an important aspect of counseling. Confidentiality means that no one outside Living Hope Counseling Center (LHCC) is given any information, including the fact that you have been here, without your expressed written consent. Our goal is to provide you with a safe environment in which you feel comfortable to discuss your concerns.

The LHCC staff members follow the professional, legal, and ethical guidelines set forth by the professional regulations of the State of Illinois and various Federal confidentiality acts in keeping the counseling relationship confidential. Please be aware that there are certain circumstances in which therapists are required to breach confidentiality without a client's permission:

- To report suspected child or elder abuse or neglect.
- In the event you threaten harm to yourself or other people.
- Information required by your insurance company as necessary to process your claim.
- Under court order. If records or information is subpoenaed by a court, information will be released only to the extent required by law.

Your counselor will be discussing your progress with supervisory staff for the purpose of supervision or consultation only. These discussions are kept confidential. Any other release of information regarding the counseling services you receive will be made only with your expressed written permission.

I have read the above information carefully and understand the counselor's social and economic responsibility to make such decisions where necessary

____________________________________ ________________________

CLIENT SIGNATURE DATE

LIVING HOPE COUNSELING CENTER
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: May 2015

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.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information.** However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (Inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our patient/customer services or benefits, the new notice will be posted on that website.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) most uses and disclosures of psychotherapy notes, (ii) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications, (iii) disclosures that constitute a sale of your health information; and (iv) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Living Hope Counseling Center or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make a complaint. The contact information for both is included below:

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: 202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Living Hope Counseling Center
Kathy Hutchins
Privacy Officer
2200 S. Sixth Street
Springfield, IL 62703
217-698-7150
217- 691-8151

NOTICE OF PRIVACY PRACTICE AVAILABILITY

The notice will be prominently displayed in the office where registration occurs. You will be provided a hard copy at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's website for downloading.

COUNSELING CENTER

2200 South Sixth Street, Springfield, IL 62703
P: 217.698.7150 F: 217.698.7085

Standard Schedule of Fees
June 2023

Individual Therapy, hourly rate	$150
Partner Church Rate (6 sessions)**	$60
Student Inter, hourly rate	$20
Cancelled Session less than 24 hours	$60
Missed Session	$60
NSF Check Fee	$25
Phone Consultation (11-30 minutes)	$25
Phone Consultation (31-45 minutes)	$50
Correspondence/Report	$50
Court Appearance – hourly rate (2 hours minimum)	$50

**Church partner rate is extended to active members of one of our current church partners. Must provide verification from church.