Bob Ryan, LCPC, ATR

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web: counselingevanston.com
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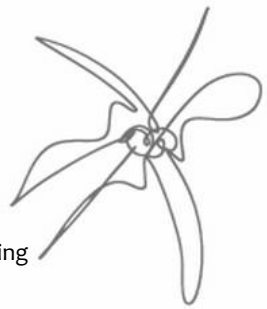
Caring Psychological Counseling



Client Name: _____ Date of Birth:_____

Legal Guardian Name (if minor):_____ Legal Sex Designation*: M F

** This information is required for insurance billing purposes only. Your counselor affirms all gender identities, presentations, and chosen pronouns.*

Is there any other information about your gender identity that you would like to share with us at this point?

_____

Billing Address:_____ May Send Correspondence: Yes No

City/State/Zip: _____

Email Address: _____ May Send Correspondence: Yes No

Home/Cell Phone:_____ Permission to Contact: Yes No

Work/Cell Phone: _____ Permission to Contact: Yes No

## PRIMARY INSURANCE

Insurance Carrier:_____ Phone Number:_____

Identification Number:_____ Group Number:_____

Is Client Policy Holder?: Yes No Policy Holder Relation to Client: Self Spouse Parent Other

Policy Holder Name:_____Policy Holder Date of Birth:_____

**Please read the following carefully and sign below:**
I authorize Robert Ryan to submit required information to my insurance company(s). I am aware that I am placing my signature on file. I also understand that I will be responsible for any unpaid balances, such as co- pays, deductibles, and non- covered services. I understand that there may be a fee if I fail to give notice for cancellation of my appointment(s). I understand that my insurance and/or EAP does not cover the cost of missed or cancelled sessions.

**Client Signature:_____ Date:_____**

**Client's Legal Guardian (if minor): _____ Date: _____**

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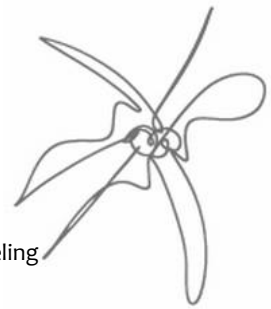


## INFORMED CONSENT & PRIVACY RIGHTS

Thank you for choosing Robert (Bob) Ryan. Today's appointment will take approximately 45 – 50 minutes. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need. Robert has earned a Bachelor of Fine Arts Degree in 1997 and a Master's Degree in Arts in Psychological Counseling: Art Therapy from Adler University in 2008. He is licensed by the State of Illinois as a Licensed Clinical Professional Counselor. He has clinical experience treating children, adolescents, adults and couples in individual and group settings. Robert practices Adlerian Psychology with an emphasis on Relational and Expressive Therapies where indicated; though other treatment approaches are used depending on the individual, couple or condition. Treatment practices, philosophy, goals and limitations of treatment will be discussed at the time of your first session.

## CONFIDENTIALITY AND EMERGENCY SITUATIONS

Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or you child or children report about physical, sexual abuse or elder abuse; then, by Illinois State Law, we are obligated to report this to the Department of Children and Family Services, c) where you sign a release of information to have specific information shared and d) if you provide information that informs us that you are in danger of harming yourself or others e) information necessary for case supervision or consultation and f) or when required by law. If an emergency situation for which the client or their guardian feels immediate attention is necessary, please call the emergency services in the community (911) for those services. We will follow those emergency services with standard counseling and support to the client or the client's family. E-mail and text messages are not secure means of communications and should not be used to convey sensitive personal information. Social networking sites are also not confidential and it is a non-ethical practice for your counselor and you to "friend" or "follow" each other on such sites.

## FINANCIAL/INSURANCE ISSUES

As a courtesy to each other we ask that fees for service be paid at the completion of each session. If your balance exceeds $260.00 we will need to ask that you pay for services before further services are rendered. After 60 days any unpaid balance will be charged 1.5% interest a month (18% APR). In the event that an account is overdue and turned over to our collection agency, the client or responsible party will be held responsible for any collection fee charged to our office to collect the debt owed.

Lastly, if you need to cancel or reschedule an appointment, please give 24 business hours advance notice, otherwise you will be billed $80. Late cancelation fees are not payable by insurance. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask.

## YOUR RIGHTS AS A CLIENT

A. **Access to Protected Health Information.** You have the right to inspect and obtain a copy of the protected health information we have regarding you, in the designated record set. Access must be provided to you within 30 days and we may charge a reasonable, cost- based fee. You can request access to an electronic or paper copy of your protected health information. You may also request a summary of your health information. There are some limitations to this right, which will be provided to you at the time of your request, if any such limitation applies. To make a request, ask your counselor.

B. **Amendment of Your Record.** You have the right to request that we amend your protected health information. UB is not required to amend the record if it is determined that the record is accurate and complete. There are other exceptions, which will be provided to you at the time of your request, if relevant, along with the appeal process available to you. If we deny your request for an amendment, we will provide you with additional information, in writing, regarding the denial within 60 days. To make a request, ask your counselor.

C. **Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures we have made regarding your protected health information in the six (6) years immediately preceding your request. However, that accounting does not include disclosures that were made for the purpose of treatment, payment, or health care operations. In addition, the accounting does not include disclosures made to you or disclosures made pursuant to a signed Authorization. There are other exceptions that will be provided to you, should you request an accounting. To make a request, inform your counselor.

D. **Additional Restrictions.** You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, unless your request is that we not disclose information to a health plan for payment or health care operations activities when you have paid for the services that are the subject of the information out-of-pocket in full. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To make a request, inform your counselor.

E. **Alternative Means of Receiving Confidential Communications.** You have the right to request that you receive communications of protected health information by alternative means or at alternative locations. For example, if you do not want bills or other materials mailed to your home, you can request that this information be sent to another address. There are limitations to the granting of such requests, which will be

provided to you at the time of the request process. To make a request, ask your counselor.

F. **Copy of this Notice.** You have a right to obtain a paper copy of this notice upon request at any time, even if you have agreed to receive this notice electronically.

G. **Choose Someone to Act for You**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your protected health information. We will verify that has this person has authority and can act for you before we take any action.

## ADDITIONAL INFORMATION

A. **Privacy Laws.** Your counselor is required by State and Federal law to maintain the privacy of protected health information. Your counselor follows any federal or state law that gives greater privacy protections than HIPAA. For example, your counselor follows the Illinois Mental Health and Developmental Disabilities Confidentiality Act concerning mental health records. In addition, your counselor is required by law to provide clients with notice of its legal duties and privacy practices with respect to protected health information. That is the purpose of this Notice.

B. **Terms of the notice and changes to the Notice.** Your counselor is required to abide by the terms of this notice, or any amended notice that may follow. Your counselor reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected health information that it maintains. When the notice is revised, the revised notice will be available upon request and will be posted on our website.

C. **Breach Notification.** Your counselor is required to notify you following a breach of your protected health information that has not been secured in a certain manner.

## NOTICE OF INFORMED CONCENT & PRIVACY RIGHTS

I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document.

**Signature _____Date_____**

**Signature _____Date_____**

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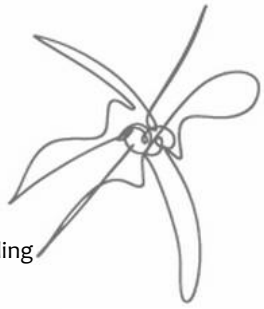

CaringPsychological Counseling

## CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS

I/We consent that _____ maybe treated as a client by Robert Ryan. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children. This consent to treat expires at the end of treatment or if revoked in writing.

**Signature(s)_____Date_____**

## COORDINATION OF TREAMENT

It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. **Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization**. If you prefer to decline consent no inform will be shared.

**____You may inform my physician(s)**

**PHYSICIAN NAME:_____**

**CLINIC:_____**

**ADDRESS:_____**

**PHONE:_____**

**Signature(s)_____Date_____**