BENDING BIRCH COUNSELING

800 Hart Road · Suite 340 · Barrington, Illinois · 60010 · Phone (224) -239-5359

Client Demographics:

Client name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone: _____ Email: _____

Age: _____ Ethnicity (optional): _____ Gender: _____ Marital Status: _____

Employment/School:

Employer/School: _____

Job Title/Grade: _____

Parent/ Guardian (if Minor): _____

Parent/Guardian Phone: _____ Parent/Guardian Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Emergency Phone: _____

Health:

Allergies: _____

Chronic Health Conditions: _____

Previous Mental Health Diagnosis: _____

If a client is using insurance, please complete the subscriber's information below.

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Employer: _____ Insurance Company: _____

Policy ID No: _____ Group No: _____ Effective Date: _____

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INFORMED CONSENT

Welcome to Bending Birch Counseling. It is a pleasure to be part of your journey. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. **Although these documents are long and sometimes complex, it is very important that you understand the presented information. When you sign this document, it will also represent an agreement between us.**

Bending Birch Counseling offers a therapeutic approach to address a wide range of mental health needs and maintains the highest caliber of evidence-based treatment protocols and program designs. Bending Birch Counseling provides individual, couples and family counseling to adults, children, and adolescents. The specializations within the practice include but are not limited to anxiety, depression, grief/loss, stress management, conflict resolution, marital and family relational issues, and life transitions.

Contact information:
We are often not immediately available by telephone, as we do not answer the phone when we are with clients or otherwise unavailable. At these times, you may leave a message on our confidential voicemail, (224-239-5359) and your call will be returned as soon as possible. We will make every attempt to return your call within 24 hours, but this cannot be guaranteed. Every effort will be made to expedite a session in the event of a personal crisis. If, for any reason, you do not hear from your clinician or they are unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe, 1) go to your Local Hospital Emergency Room, 2) call 911, or 3) call or text 988 to reach the National Suicide Prevention Lifeline.

Credentials:
Jennifer Valice, Licensed Clinical Social Worker

Licensing Regulations:
The clinicians at Bending Birch Counseling are licensed by the Illinois Department of Financial and Professional Regulation. The website is: http://idfpr.com/.

Ethical Guidelines:
As Licensed Clinical Social Workers we follow the National Association of Social Workers Code of Ethics. This can be found at http://socialworkers.org/pubs/code/code.asp. As Licensed Clinical Professional Counselors we follow the American Counseling Association Code of Ethics. This can be found at http://www.counseling.org/knowledge-center/ethics.

ABOUT THE COUNSELING PROCESS

Voluntary Participation:
Involvement in treatment is voluntary and can be terminated at any time without penalty. Court mandated clients should be aware of the consequences that may result when clients choose to abruptly terminate therapy. The clinician is required to report this termination to the proper authorities. If therapy is terminated before the time agreed upon, a referral would be given if needed. Some alternatives to traditional therapy are self-help books, pastoral counseling, support groups, and medication.

Effects of Therapy:
The clinician cannot guarantee the results of therapy; for instance, prevent a divorce, restore a relationship, or relieve depression. Therapy outcome is largely influenced by the client's characteristics such as motivation, severity of symptoms and acceptance of personal responsibility for change. If the needs of the client exceed the scope of expertise or training of the clinician, referrals will be made outside the practice as appropriate.

Benefits and Risks Associated with Counseling:
There are many benefits to the therapy process, such as the client may experience reduction in feelings of distress in the family or greater awareness of self and issues causing disruption in the marriage/family. However, during the counseling process some clients may experience disruptions in life or discomfort due to anxiety or pain related to issues discussed or discovered during the counseling process. Risks may also include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness, and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life.

Length of Therapy and Termination:
Client sessions are 50 minutes in length. The duration of therapy will be agreed upon between the client and the clinician, and consideration will be given to limits by third party payment. The first 1-2 sessions will involve a comprehensive evaluation of client symptoms and needs. By the end of the evaluation, the clinician will be able to offer some initial impressions of what the treatment might include. At that point, we will discuss the treatment goals and create an initial treatment plan. The client should evaluate this information and make their own assessment about whether they feel comfortable working with the clinician.

Consent for Treatment:
Clients have the right to withdraw from treatment at any time. If there are concerns about procedures, style, or qualifications offered by the clinician, the client is free to discontinue services. The clinician will always offer due effort in resolving concerns that arise. If no resolution can be obtained, the clinician will offer referrals outside the practice as appropriate.

Clinician Involvement:
The clinician will endeavor to be present, honest, and emphatic throughout the counseling sessions. The clinician will engage the client verbally and help the client work toward the agreed upon therapy goals. Progress of therapy will be monitored with the aid of a treatment plan. Each session will be scheduled for 50 minutes. No time adjustment will be made for late arrivals.

Client Involvement:
Clients are encouraged to be dedicated to the therapeutic process, as well as active in counseling sessions. Active involvement involves being open, honest, and present, as well as being diligent to complete homework assignments. These will positively affect the counseling process. Clients agree to show up to all appointments on time and if unable to arrive on time will call the clinician.

RIGHTS AND RESPONSIBILITIES OF THE CLIENT

HIPAA:
Please be assured that Bending Birch Counseling follows the strict policies of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You have the right to review your consumer file in the presence of your counselor, and you may ask for a copy of your file at a charge of a per-page copy fee of the standard rate. Your files and personal health information (PHI) will be kept in complete confidence and may only be disclosed with your written consent and approval.

Confidentiality and Privilege:
Your privacy and confidentiality are important to us. All sessions are confidential. This means that no verbal or written information will be released to persons or agencies regarding the fact that counseling services have been received or the nature of concerns discussed in session without written consent from the client or legal guardian if client is a minor. However, there are limits to confidentiality. The following are times when a therapist at Bending Birch Counseling may be required by law to break confidentiality.

- A danger to oneself and/or others (i.e., suicide or homicide) will necessitate the breaking of confidentiality. If a client discloses intention to harm self or others the clinician is required by law to warn the intended victim and report information to authorities.
- Suspected child abuse and/or neglect and elder abuse and/or neglect communicated by clients must be reported to appropriate agencies by counseling staff.
- There are times when your clinician may be required by law to release information due to lawsuits or court proceedings. Please know we must have a subpoena and a court order to release records without your written consent. In all of these cases we will first notify you of any requests.
- When reimbursement requires disclosure, third parties may review client records prior to reimbursement of fees.

Release of Information:
Written consent is required to release information to persons or agencies outside of Bending Birch Counseling. For minors under the age of 12 consent must be given by the legal guardian. For minors aged 12 -17 consent must be given by both the minor and legal guardian.

Counseling and Financial Records:
Client records, clinical notes, counseling contracts, and all financial records will be maintained for a period of seven years. Any release of the sessions will be done with the written approval of the client (parent/legal guardian of minor(s) younger than 12 must first give permission). These documents will be kept in a secure area within the center. After seven years, the records will be shredded. You have a right to a copy of your file. The policy is that the client will be given an appointment to review the file before being given a copy to avoid any misunderstandings or misinterpretation of the material in the file.

Court Action/Legal Fees:
The client is encouraged to speak with the clinician before waiving rights to confidentiality for any legal court cases. If required to participate, the clinician will only provide facts and not opinion regarding your services. Clients are expected to pay any cost even if the request is from a third party on the client's behalf.

Disputes and Complaints:
When disputes and/or complaints arise, clients should feel free to address their concerns with the clinician or with Bending Birch Counseling owner, Jennifer Valice, LCSW. In the event their dispute(s) or complaint(s) are not resolved clients have the right at any time to seek the assistance of the: Illinois Department of Financial and Professional Regulation. http://idfpr.com/.

RESPONSIBILITIES OF THE COUNSELOR

Colleague Consultation:
To ensure quality care for clients, frequent consultation with other mental health professionals is standard practice. Every effort will be made to protect the identity of clients.

Dual Relationships:
To maintain the integrity of the counseling process, the clinician will refrain from entering into dual or multiple relationships with the client. The clinician will always maintain a professional relationship with the client. There will be no socializing between the clinician and client outside of the counseling setting. If the clinician sees the client in a public place, to maintain confidentiality the clinician will only acknowledge the client if it is first initiated by the client. Please consider that if you speak to your clinician in public, you may be hindering your privacy.

MINOR CLIENTS

Illinois law states that minors aged 12 to 17 can consent to outpatient therapy without parental consent for a total of five sessions lasting no longer than 45 minutes each. The clinician is not legally able to disclose the minor being in session to parents or guardians, except for imminent threat of harm to self or others. After five sessions, parental notification and consent are required to continue treatment.

You are encouraged to ask any questions you may have concerning the above policies, either now or as they occur.

CLIENT ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read and understand the information presented in this document, I give consent to the terms of this document and agree to enter into a counseling relationship with the clinician at Bending Birch Counseling, and that I have also been given a copy of this document. By signing below, I am consenting to treatment at Bending Birch Counseling.

Signature of Client:_____ Date: _____

Signature of Client:_____ Date: _____

Signature of Parent or Guardian:_____ Date: _____

COMMUNICATION POLICY

Your privacy is important to us. This document outlines our office policies related to the use of social media, email, and the internet. Please read it to understand how we handle possible online connections and how you can expect us to respond to interactions that may occur between us on the internet. Please discuss any questions or concerns you may have with your therapist.

Email:

To protect your privacy, please use the email address: jennifer@bendingbirchcounseling.com for administrative reasons only (modifying appointments, billing information, etc.). Please do not email content related to counseling sessions, therapeutic issues, etc. Email communication cannot be guaranteed as secure or confidential. Any emails we receive from you and any responses we send to you become part of your medical record.

Text Messages:

Texting may be used to modify appointment times or other brief notifications. Any text message we receive from you or send to you becomes part of your medical record.

Friending/Fanning:

To protect your privacy, as well as our own, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Adding clients as friends on these sites can compromise your confidentiality and other therapeutic relationships. In turn, we will never solicit your endorsement.

Following:

We do not follow clients on Twitter, Instagram, blogs, or other apps/websites. If there is content you wish to share from your online life, please bring it into our sessions where we can explore it together.

Search Engines:

It is not a regular part of our practice to search for clients on Google, Facebook, or other searchable sites. An exception could be during a crisis. If we have reason to suspect you are a danger to yourself or others and we have exhausted all other reasonable means to contact you and/or your emergency contact, then we may use a search engine for information to ensure your welfare. If this ever occurs, your therapist will fully document the search and discuss it with you at your next session.

Location-Based Services:

Please be aware if you use location-based services on your mobile phone you may compromise your privacy while attending sessions at our office. Enabled GPS tracking makes it possible for others to surmise you are a counseling client due to regular check-ins at our office location.

Appointment Reminders:

All appointment reminders are automated and will be made via text, phone, or email.
I prefer to receive appointment reminders via (check all that apply)

EMAIL: ____TEXT: ____CALL: ____VOICEMAIL: ____NONE: ____

_____ **I will be responsible for missed appointment fees.**
(initial)

By signing below, I acknowledge that I have read and understand the communication policy of Bending Birch Counseling.

Signature of Client:_____Date: _____

Signature of Client:_____Date: _____

Signature of Parent or Guardian:_____Date: _____

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AUTHORIZATION FOR TELEHEALTH SERVICES

Purpose
The purpose of telehealth services is to provide remote therapy services to existing and new clients. Telehealth sessions will be conducted via telephone or a HIPAA compliant video platform, based on client preference.

Confidentiality
Please be assured that Bending Birch Counseling follows the strict policies of the *Health Insurance Portability and Accountability Act of 1996* (HIPAA). ***Telehealth sessions will never be recorded and still images will never be captured***.

Financial Agreement
Telehealth services will be billed the same as in-office services. Clients are responsible for copays, co-insurance, and any services not covered by insurance.

Rights
Clients may withdraw consent for telehealth services at any time without affecting their right of future care or treatment.

By signing below, I acknowledge that I have read and understand the information presented in this document and agree to telehealth services at Bending Birch Counseling.

Signature of Client:_____ Date: _____

Signature of Client:_____ Date: _____

Signature of Parent or Guardian:_____ Date: _____

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AUTHORIZATION FOR CREDIT CARD USE

Bending Birch Counseling requires that a credit, debit, FSA, or HSA card be kept on file at all times during treatment.

- All payments are due at the time of service.
- Paper statements are not offered unless superbills are needed for submission to out of network benefits.
- If using FSA or HSA an additional card must be provided in the event funds are no longer available.
- Outstanding balances, exceeding 30 days past due, may result in postponement of further sessions until the account has been reconciled in full.
- I understand that there will be a $75.00 No Show fee applied to my account for all missed appointments not cancelled within 24 hours.

I authorize Bending Birch Counseling to charge the amount of any outstanding balance after insurance has been reconciled. I agree to pay for any outstanding balance on my account, congruent with the set fee identified between my clinician and myself. Each purchase is in accordance with the issuing bank cardholder agreement.

Name as it Appears on Card: _____

Billing Address: _____

City, State: _____ Zip Code: _____

Last 4 Digits of Credit Card on File: _____

Cardholder – Please Sign and Date:

Signature: _____ Date: _____

Print Name: _____

The information below will be destroyed after being entered into our accounting system.

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

Credit Card Number: _____

Expiration Date: _____ CVV Number: _____
(3- or 4-digit number located on the front or back of card)