

Studio For Change[®]

3020 N. Lincoln Avenue
Chicago, Illinois 60657
773-281-8130

Adult Intake Information & Outpatient Services Contract

NAME _____ DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMERGENCY CONTACT _____ PHONE# _____ RELATIONSHIP _____

INSURANCE INFORMATION

INSURED'S NAME AND ADDRESS _____

SS# _____ INSURANCE COMPANY _____

ADDRESS _____

GROUP NO. _____ INSURED'S EMPLOYER _____

WORK NO. _____ REFERRAL SOURCE _____

Welcome to the Studio For Change[®]!

This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting. Once you sign this, it will constitute a binding agreement between you and the Studio For Change.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular problems that the client brings. There are a number of different approaches, which can be utilized to deal with the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, your therapist will be happy to help you to secure an appropriate consultation with another mental health professional.

Meetings

The Studio For Change normal practice is to conduct an evaluation which will last from two to four sessions. During this time, you and the therapist can both decide whether your therapist is the best person to provide the services that you need in order to meet your treatment objectives. If psychotherapy is initiated, your Studio For Change therapist will usually schedule one 50-minute session (one appointment hour of 50 minutes' duration) per week at a mutually agreed time, although sometimes sessions will be scheduled longer or more frequent.

Cancellation & Rescheduling Policy

The Studio For Change requires 24 hour notice for any cancelled appointments. Therapy appointments must be cancelled or rescheduled 24 hours before the scheduled date and time. Any same day cancellations or no call, no shows are subject to a cancellation fee of your full therapy fee. For such purposes we require a credit card number on file. *See the last page in this document to leave credit card information and to sign the client acknowledgement of this policy.*

Contacting Your Therapist

Your therapist may not be immediately available by telephone. While we are usually in the Studio For Change office during the week, we usually do not answer the phone when with a client. When your therapist is not available, a confidential voice mailbox that is monitored frequently answers our telephone. Your therapist will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If you cannot reach your therapist, and you feel that you cannot wait for a return call, you should call your family physician, 911, or the emergency room at the nearest hospital and ask for the psychiatrist or psychologist on call. If your therapist is unavailable for an extended period of time, you will be provided with the name of a trusted colleague whom you can contact if necessary.

Drug and Alcohol Policy

The Studio For Change requests that clients seeking services be drug and/or alcohol free during therapy appointments. That is, no illicit drugs or alcohol are to be consumed prior to a therapy session.

Supervision

Your Studio For Change therapist may be working towards a professional license to practice. Despite your current therapists licensing status, your Studio For Change therapist does meet the appropriate educational and experiential requirements to treat clients in this practice. Per the State of Illinois licensure requirements, and the appropriate therapist's licensing governing body, your therapist will be in on-going supervision with a licensed clinical therapist. This is to ensure your Studio For Change therapist meets all state regulations and ethical guidelines in accordance with your therapeutic services and in order to work towards earning said license. Note that your therapist's approved clinical supervisor will have access to your client file and information. You have the right to know and contact the licensed, clinical supervisor overseeing your case at any point in time. Again, in order to be accurately supervised, your therapist's approved supervisor may request or observe a video and/or audio recording of our therapy sessions as a part of the training (see a/v consent below). All approved supervisors are also held to the same confidentiality requirements as your therapist. Your Studio For Change therapist will be open about his or her credentials and licensing status. You are encouraged to discuss this with your therapist.

Payments & Billing

Professional Fees

The Studio For Change bills at a rate of \$120-\$150 per hour or based on your income, a sliding fee scale may be initiated. In addition to weekly appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations with other professionals that you have authorized, preparation of records or treatment summaries, or the time required to perform any other service that you may request of me. If you become involved in litigation that requires our participation, you will be expected to pay for the professional time required even if I am compelled to testify by another party, should this be part of your therapy. Because of the complexity and difficulty of legal involvement, what you are charged will be assessed and an increase in your hourly fee plus traveling expenses for preparation for and attendance at any legal proceeding. Please discuss this with your therapist prior to initiating Studio For Change in any legal proceedings.

Overdue Payments

If your account is more than 60 days in arrears and suitable arrangements for payment have not been agreed to, Studio For Change has the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information Studio For Change therapist release about a client's treatment would be the client's name, the nature of services provided, and the amount due.

Insurance Reimbursement

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Studio For Change will provide you with whatever assistance your therapist can in facilitating your receipt of the benefits to which you are entitled including filling out forms as appropriate. However, you and not your insurance company are responsible for full payment of the fee that we have agreed to. All of our insurance billing is out-serviced through American Medical Billing (AMB) and invoices for claims not paid by insurance will be sent directly to clients from AMB.

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan administrator and inquire. Of course, Studio For Change will provide you with whatever information your therapist can based on our experience and will be happy to try to assist you in deciphering the information you receive from your carrier. If necessary to resolve confusion, your therapist is willing to call the carrier on your behalf. The escalation of the cost of health care has resulted in an increasing level of complexity about insurance benefits, which sometimes makes it difficult to determine exactly how much mental health coverage is available. "Managed Health Care Plans" such as HMOs and PPOs often require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented toward a short-term treatment approach designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In our experience, while quite a lot can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire.

You should also be aware that most insurance agreements require you to authorize your therapist to provide a clinical diagnosis and sometimes additional clinical information such as a treatment plan or summary or in rare cases a copy of the entire record. This information will become part of the insurance company files, and, in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, your therapist will have no control over what they do with it. In some cases they may share the information with a national medical information data bank. If you request it, your therapist can provide you with a copy of any report submitted.

Once Studio For Change has all of the information about your insurance company, your therapist will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself and avoid the complexities described above.

Paying Your Bill

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of unusual financial hardship, your therapist may be willing to negotiate a fee adjustment or installment plan.

As a courtesy, we will bill your insurance company, HMO or responsible party if you wish. We ask that at each session you pay your co-pay or 50% of the fee. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your balance exceeds, \$300.00, we will need to ask that you pay for services when rendered. After 60 days any unpaid balance may 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, we ask that every client authorize payment of medical benefits directly to the Studio For Change. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments, please feel free to ask.

(Check **ONE** box for the payment option you choose to pay your bill and sign below)

I agree to use my **insurance to pay for services** understanding that I am responsible for all unpaid claims.
Signature _____ Date _____

OR

I am **not paying with insurance**, but I agree to pay \$_____ amount for each session.
Signature _____ Date _____

Client Records & Confidentiality

Professional Records

The Studio For Change needs to ensure you are aware that your therapist is required to keep appropriate records of your work together such as dates seen and services performed. These records are kept in your main file along with your contact information and are kept in a locked file cabinet. At times, your therapist may record psychotherapy notes from our sessions. Because these records contain information that can be misinterpreted by someone who is not a mental health professional, it is our general policy that clients may not review them.

Confidentiality

In general, the law protects the confidentiality of all communications between a client and a therapist, and your therapist can only release information about your work to others with your written permission. However, there are a number of exceptions.

In most judicial proceedings, you have the right to prevent your therapist from providing information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your therapist's testimony if he or she determines that resolution of the issues before him or her demands it.

There are some situations in which your therapist is legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if your therapist believes that a child, an elderly person, or a disabled person is being abused, we are required to file a report with the appropriate state agency.

If your therapist believes that a client is threatening serious bodily harm to another, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him or herself, your therapist may be required to seek hospitalization for the client or to contact family members or others who can help provide protection.

The situations described above have rarely arisen in our practice. Should such a situation occur, your therapist will make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, your therapist will make every effort to avoid revealing the identity of our client. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, your therapist will not tell you about these consultations unless they feel that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. The laws governing these issues are quite complex, and your therapist is not an attorney. While your Studio For Change therapist is happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable. If you request, your therapist will provide you with relevant portions or summaries of the applicable state laws governing these issues.

Confidentiality and Emergency Situations:

Your verbal communication and clinical records are strictly confidential except for: a) information you and your child or children report about physical or sexual abuse; then, by Illinois State Law, your therapist is obligated to report this information to the Illinois Department of Children and Family Services, b) information shared with your insurance company to process your claims, c) where you sign a release to have specific information shared, d) if you provide information that informs me that you are in danger of harming yourself or others. If an emergency arises for which the client or their guardian feels immediate attention is necessary, the client or the guardian understands they are to contact the emergency services in the community for those services. Your Studio For Change therapist will follow those emergency services with standard counseling and support to the client or the client's family.

Signature _____ Date _____

Consents for Treatment

Minors

If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. For those who are between 12 and 18 years of age, it is our policy to request an agreement from parents that they consent to give up access to your records. If they agree, your therapist will provide them only with general information about our work together unless your therapist feels that there is a high risk that you will seriously harm yourself or another, in which case your therapist will then notify them of concern. Your therapist will also provide them with a summary of your treatment when it is complete if they have opted to let our work be confidential. Before giving them any information your therapist will discuss the matter with you, if possible, and will do the best we can to resolve any objections you may have about what we are prepared to discuss. *See the Child Intake Information & Outpatient Services Contract to consent a minor for treatment.*

Audio/Visual Consent

As a learning tool, your Studio For Change therapist may sometimes utilize audio and/or video recording devices during a therapy session. The purposes of these tapes are for supervision and learning only. They will only be viewed by your therapist and their approved, licensed supervisor. You will never be recorded in any manner without your acknowledgement or consent, nor will there ever be any secret recordings of you in a therapy session. If deemed appropriate for the therapy, the video and/or audio tape may be played in a therapy session for you (the client) and your therapist to review. All audio and video recordings are stored confidentially in the same manner as your treatment records and destroyed at the time of therapy termination.

Please check the appropriate boxes: I consent to allow my therapist to **audio tape** and/or **video tape** our therapy sessions as deemed appropriate for my therapy. I understand that I have the right to ask the therapist to stop recording at any point in time and know that any information shared on the tape will be managed in a confidential manner as indicated above.

Signature _____ Date _____

Signed Consent to Receive Services

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

Signature _____ Date _____

Therapist Signature _____ Date _____

Additional Client(s) Receiving Services from Studio For Change

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

Print Name _____ Signature _____ Date _____

Print Name _____ Signature _____ Date _____

Adult Intake Questionnaire

Background Information

1. Preferred name to be called/Nickname: _____
2. Gender Identity (circle): Male, Female, Other, specify: _____
3. Marital Status (circle): never married, partnered, married, separated, divorced, or widowed
4. Is it OK to leave voice messages on any of the following phone numbers?
(Check all that apply and write in):
 - a. Home #: _____
 - b. Work #: _____
 - c. Cell #: _____
 - d. Other #: _____
5. Ethnic Identity: _____
6. Religious/Spiritual Preference(s): _____
7. Why are you seeking psychotherapy at this time? _____

8. How would you currently rate the problem(s) you are seeking help with at this time?
Use a scale from 1 to 5; 1=not intense and 5 = extremely intense _____
9. How long has the current problem(s) been occurring? _____
10. Please list your current coping strategies in dealing with the problem(s): _____

11. Are you currently receiving other mental health services, counseling or psychotherapy elsewhere?
Yes No (circle one)
If **yes**, what services, where and how often? _____

12. Have you ever received counseling or therapy before? **Yes No** (circle one)
If **yes**, for what purposes? _____

What services were helpful and why? _____

What services were unhelpful and why? _____

Mental Health

1. Are you currently experiencing any suicidal thoughts?

Circle one: frequently, sometimes, rarely, never

2. Have you ever experienced suicidal thoughts?

Circle one: frequently, sometimes, rarely, never

3. Have you ever intentionally inflicted any harm on yourself? **Yes No** (circle one)

If **yes**, please explain: _____

4. Have you ever intentionally inflicted any harm on someone else? **Yes No** (circle one)

If **yes**, please explain: _____

5. Have you ever been hospitalized for mental health issues? **Yes No** (circle one)

If **yes**, please provide when, where and reason: _____

Physical Health

1. How would you rate you current physical health? _____

2. Have you ever been hospitalized for a physical condition? **Yes No** (circle one)

If **yes**, please provide when, where and reason: _____

3. So you have any difficulties with sleep? **Yes No** (circle one)

If **yes**, what and how often? _____

4. Any recent appetite or eating changes? **Yes No** (circle one)

If **yes**, circle **any** that may apply: weight gain, weight loss, food restriction, bingeing, eating more, eating less

And, please explain: _____

5. Do you exercise? **Yes No** (circle one)

If **yes**, what is the duration (in minutes/hours) of your typical exercise session? _____

How many times per week? _____

6. Do you have any problems or worries about sexual functioning? **Yes No** (circle one)

If **yes**, please explain: _____

Substance Use

1. Do you smoke? **Yes No** (circle one)
If **yes**, how much and how often? _____

 2. Do you currently drink alcohol? **Yes No** (circle one)
If **yes**, how many drinks per week on average to you consume? _____

 3. Has anyone in your family currently have or has had in the past a substance abuse problem and/or an alcohol abuse problem? **Yes No** (circle one)
If **yes**, please explain: _____

 4. Are you currently taking any prescribed psychiatric medication(s)? **Yes No** (circle one)
If **yes**, please list medication(s) and dosage: _____

 5. Have you ever been prescribed psychiatric medications(s) in the past? **Yes No** (circle one)
If **yes**, please list medication(s) and dosage: _____

 6. Are you currently taking any other substance(s) (i.e.: recreational drugs, non-prescribed psychiatric or general medication(s), illicit substances, etc.)? **Yes No** (circle one)
If **yes**, please list substance(s) and dosage: _____

- And, approximately how many times per week are you are you consuming the abovementioned substance(s)? _____

Family Background

1. Please list current members of your family, including significant others if not married:

| Name | Age or Date of Birth | Occupation/Year in School |
|------|----------------------|---------------------------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

2. Please list any information about your family relationships (i.e. divorce, extended family issues, past abuse experienced or witnessed as a child, etc.): _____

3. Have any of your family members ever been diagnosed with an emotional disorder, such as depression, anxiety, bi-polar disorder, etc.? **Yes No** (circle one)
If **yes**, please explain: _____

4. Have any of your family members ever been diagnosed with any learning issues or disabilities?
Yes No (circle one)
If **yes**, please explain: _____

Legal Concerns

1. Are you or any immediate family members currently involved in any court case? **Yes No** (circle one)
If **yes**, please describe: _____

2. Are you currently involved in divorce mediation or a custody case? **Yes No** (circle one)
If **yes**, please describe: _____

3. Is there currently a custody agreement in place? **Yes No** (circle one)
If **yes**, please describe agreement: _____

Please list anything else you would like your Studio For Change® therapist to know about you or your family before you initiate therapy:

Studio For Change® Cancellation & Rescheduling Policy

Please be advised that the Studio For Change® requires 24 hour notice for any cancelled appointments. Therapy appointments must be cancelled or rescheduled 24 hours before the scheduled date and time. Any same day cancelations or no call, no shows are subject to a cancellation fee of your full therapy fee of \$_____ (write your weekly billing amt. in blank). For such purposes we require a credit card number on file.

Type of Card (check one): Visa MasterCard Discover

Name on Card (please print) _____

Credit Card number _____ Expiration Date # _____

3 Digit Code on back _____

Card Holder's Billing Address _____ Apartment, Suite # _____

City _____ State _____ Zip _____

By my signature below, I certify that I understand that this credit card information is to remain on secure file with Studio For Change until the termination of treatment; All treatment charges will be billed with this credit card unless I request otherwise.

Signature of Card Holder _____ Date _____

I authorize the Studio For Change® office to charge my credit card the full therapy fee of \$_____, to pay for my therapy services (*Check box only if you are also planning on paying for all treatment charges with this credit card*)

***Studio For Change® Cancellation & Rescheduling Policy
Client Acknowledgement***

By my signature below, I certify that I have read and fully understand the contents of this permission form and that the disclosures referred to herein were made by me.

I authorize the Studio For Change® office to charge my credit card the full therapy fee of \$_____ (write your weekly billing amt. in blank), if I do not cancel or reschedule my appointment with 24 hour notice.

Signature _____ Date _____