CROSSROADS COUNSELING SERVICES PLLC

(Revised 07/09/2020)

PATIENT INFORMATION-PLEASE COMPLETE ALL INFORMATION

PATIENT NAME (LAST, FIRST, M.)			DOB	AGE
ADDRESS: STREET		CITY	STATE	ZIP
SSN:	MARTIAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOW	**HOME PHONE: ( )** **MOBILE PHONE: ( )** **EMAIL ADDRESS:**		
Employer:		Address:		Phone:
Spouse Name:		DOB:		SSN:
Spouse Employer:		Address:		Phone:

If this Patient is a Minor please fill out information below.

MOTHER'S NAME (LAST, FIRST, M)		DOB:
ADDRESS (IF DIFFERENT THAN PATIENT)		PHONE NUMBER:
PLACE OF EMPLOYMENT AND ADDRESS:		SSN
WORK NUMBER:		
FATHERS NAME (LAST, FIRST, M)		DOB:
ADDRESS (IF DIFFERENT)		PHONE NUMBER
PLACE OF EMPLOYMENT AND ADDRESS		SSN
WORK NUMBER		

DIVORCE SITUATIONS: It is *<u>our policy</u>* that any amount left owed after insurance has paid is the responsibility of the *parent who brings the child for their appointments*. We do not bill to anyone other than the parent who initiated the appointment. No exceptions.

INSURANCE INFORMATION

1. PRIMARY INSURANCE NAME:		POLICY ID:	GROUP ID:
SUBSCRIBER'S NAME:		DOB:	SSN:
INSURANCE PHONE NUMBER:	PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: EXPLAIN		
2. SECONDARY INSURANCE NAME:		POLICY ID:	GROUP ID:
SUBSCRIBER'S NAME:		DOB:	SSN:
INSURANCE PHONE NUMBER:	PATIENTS RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER: EXPLAIN		

What is your ethnic background? American Indian/Alaskan Native___ Caucasian___ Black/African American___ Native Hawaiian/Pacific Islander___ Asian___ Hispanic____ Decline to specify___

Preferred Language_____

IN CASE OF EMERGENCY

NAME OF CLOSEST RELATIVE:	RELATIONSHIP TO PATIENT	HOME/MOBILE PHONE #

The above mentioned is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I *<u>am financially responsible for any and all balances.</u>* I also authorize Crossroads Counseling Services, PLLC to release any information required to process my claims to the insurance. I also understand that if my account becomes delinquent and is sent over to collections there will be a 25% fee accessed on the account balance.

PATIENT/GUARDIAN SIGNATURE: **DATE:**

Crossroads Counseling Services, PLLC

FINANCIAL/INSURANCE POLICY

As a courtesy, Crossroads Counseling Services PLLC will bill your insurance company, responsible party or third-party payer. Insurance companies require that we collect all copays at each session. If your insurance company denies payment, denies coverage for services rendered or a deductible is owed, payment in full is required for the balance due.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise a missed appointment/late cancel fee will be charged. Those fees are as follows:

MD/DO/APRN:	$25/$50 missed appt./late cancel fee
LCPC/LCSW/CADC:	$65 missed appt./late cancel fee
Psy.D	$75 missed appt./late cancel fee
LPC/Sliding Scale Services	$30 missed appt./late cancel fee

Checks which are declared non-sufficient funds or stop payment, will be charged a $25.00 service fee.

Accounts turned over to a collection agency for non-payment will have a 25% fee accessed on the account balance.

Insurance will not reimburse for review of records, extensive phone consultation or correspondence, travel time, legal fees and time for responding to subpoena's or court orders, depositions, and missed appointments. These services provided for the client will be billed as separate fees and you may be required to pay a retainer before these services are rendered.

While we try to be as accurate as possible when verifying benefits, your fees may change depending on your eligibility and benefits during the date of your sessions. We can only estimate and will not know exact fee owed until we bill your insurance and get your explanation of benefits back from your insurance company.

My fee schedule has been discussed with me prior to initial appointment. _____
(Initials)

I authorize my insurance benefits to be paid directly to Crossroads Counseling Services PLLC. I understand that I am financially responsible for any balance. I also authorize Crossroads Counseling Services PLLC or insurance company to release any information required to process my claims. I have read and accept the Crossroads Counseling Services PLLC financial policy noted above.

Signature_____Date_____
(Client signature 12 years and older)

Signature_____Date_____
(Parent/Legal Guardian-Guarantor)

Revised 07/09/2020
Approved by A. Solis

INFORMED CONSENT

Thank you for choosing _____ at Crossroads Counseling Services.
(Your Therapist/Clinician's Name)

Today's appointment will take approximately 50-60 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.

All the providers at Crossroads Counseling Services, PLLC are licensed and or credentialed in their respective fields. Crossroads Counseling Services, PLLC has providers that include professionally licensed independent contractors. Therapists practice standard cognitive-behavior therapy for most conditions, although other treatment approaches are used depending on the person or condition. Treatment practices, philosophy, plan limitations and risks will be discussed with you today. In the unlikely event that your provider is unable to provide ongoing services, Angela Solis or another assigned licensed clinician through Crossroads Counseling Services will provide those services or we may refer you to an establishment outside of Crossroads Counseling Services, PLLC. Angela Solis, LCPC, CADC may be contacted at 815-941-3882. Your medical records will be either on-site or with your treating provider for seven years.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

Your verbal communication and clinical records are strictly confidential except for:

a) Information shared with our medical director when medically necessary,
b) Information (diagnosis and dates of service) shared with your insurance company to process your claims
c) Information you and / or your child or children report about physical, sexual or elder abuse; then, by Illinois State Law, I am obligated to report this to the Department of Children and Family Services,
d) Where you sign a release of information to have specific information shared and
e) If you provide information that informs me that you are in danger of harming yourself or others
f) Information necessary for case supervision or consultation and
h) Or when required by law.

If you are determined to be a clear and present danger to yourself or others, developmentally or intellectually disabled then we are mandated to report you to the Department of Human Services.

It is the policy of Crossroads Counseling Services, PLLC to treat all individuals in a way to not discriminate with regard to race, color, religion, national origin, age, sex, sexual orientation, gender identity or expression, or disability.

If an emergency situation for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency services in the community (911) for those services. Crossroads Counseling Services, PLLC clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

E-mail, text messages and social networking sites are not confidential, and we may not be able to respond.

Signature(s)_____ Date_____
(Client signature 12 years or older)

Signature(s)_____ Date_____
(Parent / Legal Guardian)

RIGHT TO RECEIVE CHANGES IN POLICY

You have the right to receive any future policy changes secondary to changes in state and federal laws. This can be obtained from the office manager.

RIGHT TO REFUSE TREATMENT

You have the right to refuse treatment or any specific treatment procedure and a right to be informed of the consequences resulting from such refusal.

Signature: _____ Date: _____

NOTICE OF HIPAA PRIVACY PRACTICES AND CLIENT RIGHTS:

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

Signature(s)_____ Date_____
(Client signature 12 years or older)

Signature(s)_____ Date_____
(Parent / Legal Guardian)

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I / We consent that _____ may be treated as a client by
(Client Name)
Crossroads Counseling Services, PLLC. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the most timely treatment for you and your children.

Signature(s)_____ Date_____
(Parent / Legal Guardian)

CONSENT FOR COMMUNICATION:

I/We consent that _____ may be contacted by Crossroads Counseling Services, PLLC
(Client Name)

Please Circle One:
I prefer appointment reminders to be sent to me via this communication: Phone E-mail

E-mail Address: _____
Preferred Phone Number (for appointment reminders): _____
Other:_____

Supplemental Consent for Minor Patient:

_____

Print Child's Name

This Supplemental Consent for Minor Patients should be used with the Crossroads Counseling Services, PLLC ("Crossroads") standard Patient Registration pack. (NOT APPLICABLE TO DCFS CONTRACT REFERRALS)

We look forward to working with you child. However, this document provides our policies when providing services.

Non-Participation in Litigation

Purpose of Minor Counseling.

Crossroads provides counseling to minors with the intention of offering minor patients a safe space to discuss whatever struggles or other circumstances the minor child is facing and a neutral party with whom to discuss such topics.

Non-Participation.

You agree that neither Crossroads, nor any Crossroads Therapist, will become involved in any legal dispute or custody matter with respect to the minor patient. In other words, we will not testify or appear in court for any reason.

Notice of Non-Participation.

You acknowledge that Crossroads has explained this policy before the minor child's first appointment. Your agreement to this policy means that you will not cause or attempt to cause any Crossroads therapist to testify for any reason.

Referrals for Disagreement.

If you do *not* agree to this condition, we will refer the minor patient elsewhere for appropriate counseling. In other words, you must agree to this document for us to provide services to your child.

Mandated Reporting

Legally Required Reporting.

In addition to the firearms mandated reporting described in our standard patient registration packet, we are also obligated to report other situations, as detailed below.

- Illinois law requires us to report to the Department of Children and Family Service if we have reasonable cause to believe that a child who is known to us in our professional capacity may be abused or neglected. It is our policy to notify you first. Illinois law also requires us to report any abuse of elders or vulnerable adults to the Department of Health and Human Services. This may include physical, sexual, financial, or psychological abuse, neglect, or exploitation.

- If you tell us that you intend to cause serious mental or physical harm to a specifically identifiable victim, including yourself, and we determine that you present a clear and imminent risk of harm, Illinois law requires that we warn the potential victim and the authorities (e.g., police). This means that we may disclose otherwise confidential information for this purpose.

By signing below, I, as the parent or legal guardian of the minor patient, acknowledge that I am competent, understand this policy, and have been provided material information regarding this document. Further, I acknowledge that I have been fully informed of Crossroad's Non-Participation in Litigation policy.

Crossroads has offered me ample time and opportunity to discuss my concerns, and all my questions have been answered to my satisfaction. Thus, I hereby provide my informed consent to the policies described in this document.

PARENT/LEGAL GUARDIAN:

_____

Please Print Name

_____ _____

Date Signature

Crossroads Counseling Services, PLLC
Helping your mental health grow

Crossroads Counseling Services, PLLC

Prompt, Professional, and Courteous

- ✓ Individual and Family Therapy
- ✓ Substance Abuse Counseling
- ✓ Medication Management

Informed Consent for Telehealth Services

In some cases, we can use electronic communications to enable you and us to connect through live interactive video and audio communications. This is called "telehealth" and may include psychological health care, diagnosis, consultation, treatment, referral to resources, education, and related services. Please carefully review sign this informed consent for telehealth services, which sets forth the terms of our relationship. I, the undersigned patient, understand that I have the below rights.

1. The laws that protect the confidentiality of my personal information also apply to telehealth. A copy of this document and our HIPAA Notice of Privacy Practices are available upon your request.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal, and relational issues, there is no guarantee that all treatment of all patients will be effective. Thus, I understand that while I may benefit from telehealth, results can not be guaranteed or assured.
4. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of professional, that: (i) the transmission of my personal information could be disrupted or distorted by technical failures; (ii) the transmission of my personal information could be interrupted by unauthorized persons; and (iii) the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. We utilize secure, encrypted HIPAA compliant audio and video transmission software to deliver telehealth.
5. Crossroads Counseling Services, PLLC adheres to Illinois laws and regulations in the provision of telehealth services. Each of our workforce members has received training to provide telehealth services.
6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for telehealth services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
7. Recording of a session is never allowable, and permission must be granted before authorizing the recording of a session. It is not permitted ever to record any session without the expressed written permission from the participants and this therapist.

› ***Payment for Telehealth Services***. We bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and deductibles apply. If insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

› ***Contingency Plan for Technology Failure***. The most reliable backup is a phone. Therefore, it is recommended that you always have a phone available and that your counselor knows your phone number. If you get disconnected from a video conferencing or chat session, please end and restart the session. If you are unable to reconnect within ten minutes, we will call you during our session time.

› ***Indemnification and Assumption of Risk***. As a condition of receiving services from us to the greatest extent permitted by law, you agree to indemnify Crossroads against all claims, liabilities, losses, damages, suits, costs, and expenses (including reasonable attorney's fees) relating to your failure to follow our instructions or lack of communication to Crossroads about any problems you encounter during our treatment of you, and you agree to assume all risk of property damage, injury, or death associated such failure. We will discuss the anticipated risks and benefits of and alternatives to our work together, and you will have an opportunity to ask questions. The terms of this indemnification and assumption of risk policy shall survive the expiration date of any treatment.

› **Patient Consent to the Use of Telehealth**. I, the undersigned, have read and understood the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described in this document. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Parent/Guardian Name	Signature	Date
_____	_____	_____
Clinician Name	Signature	Date

Crossroads Counseling Services, PLLC
Helping your mental health grow

Crossroads Counseling Services
Prompt, Professional, Courteous

- Individual & Family Therapy
- Substance Abuse Treatment
- Medication Management Treatment

Payment Guarantee + Agreement to Pay

We ask all clients to keep a current credit card on file. By providing your credit card information below, you authorize us to charge unpaid balances and fees of any kind to this card. The most common charges include the cost of professional services and cancellation fees. We will save this credit card information in your file for future charges. You also agree to pay all costs you incur for our services that are not paid by your insurance.

After insurance has processed your claim, we will charge this card for all remaining balances that are less than $250. For amounts over $250, prior to charging your card, we will notify you by phone. If we cannot reach you, we will leave a voicemail and charge this card.

_____ _____ _____
Name on Card Phone Number Email

_____ _____ _____
Card Number Expiration Date Security Code

Relation to the client: ❒ Client's card | ❒ Describe: _____

❒ Visa | ❒ Mastercard | ❒ AMEX | ❒ Discover | ❒ Other: _____

_____
Card billing address: Street Address City State Zip

You authorize all recurring charges for the follow individuals to be charged to your card.

_____ _____
Client name Date of birth

_____ _____
Client name Date of birth

_____ _____
Client name Date of birth

You may terminate this authorization at any time. But any unpaid amounts will first be charged to this card. Accordingly, you, the cardholder, hereby authorizes the above credit card to be charged for agreed purchases or services, including cancellation, or returned check charges, and to be saved to our file.

_____ _____
Cardholder Signature **Date**

Crossroads Counseling Services, PLLC
Helping your mental health grow

HIPAA NOTICE: Your Information. Your rights. Our responsibilities

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.

Effective date: January 1, 2021

Crossroads Counseling Services, LLC has been and will always be totally committed to maintaining client confidentiality. **Angela Solis** is our Privacy Officer and can be contacted at **815-941-3882.** We are required by law to maintain the privacy and security of your protected health information. We will follow the duties and privacy practices in this notice. We will only release healthcare information about you in accordance with federal and state laws and ethics of the counseling profession.

Uses and disclosures of your health information for the purposes of providing services and your rights. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment: We may need to use or disclose health information about you to provide, manage or coordinate your care or related services. Which could include consultants, other professionals who are treating you and potential referral sources.

Payment: Information needed to verify insurance coverage and/or benefits with your insurance carrier, to process your claims as well as information needed for billing and collection purposes. We may bill the person in your family who pays for your insurance.

Healthcare Operations: We may need to use information about you to review our treatment procedures and business activity. Information maybe used for certification, compliance and licensing activities.

Other uses or disclosures of your information which does not require your consent: There are some instances where we may be required to use and disclose information without your consent. For example, but not limited to: Reporting suspected abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety. As stated in the informed consent section, Confidentiality and Emergency Situations, for other uses or restrictions of your information based on State or Federal law. Information shared with law enforcement if a crime is committed on our premises or against our staff or as required by law such as a subpoena or court order.

Right to request how we contact you: It is our normal practice to communicate with you at your home address and daytime phone number you gave us when you scheduled your appointment, about health matters, such as appointment reminders etc. Sometimes we may leave messages on your voicemail. You have the right to request that our office communicate with you in a different way.

Right to inspect and copy your medical and billing records: You have the right to inspect and obtain a copy of your information contained in your medical records. To request access to your billing or health information, contact the Privacy Officer. Under limited circumstance we may deny your request to inspect and copy. If you ask for a copy of any information, we may charge a reasonable fee for the costs of copying, mailing and supplies.

Right to add information or amend your medical records: If you feel that information contained in your medical record is incorrect or incomplete, you may ask us to add information to amend the record. We will make a decision on your request with 60 days, or some cases within 90 days. Under certain circumstance, we may deny your request to add or amend information. If we deny your request, you have a right to file a statement that you disagree. Your statement and our response will be added to your record. To request an amendment, you must contact the Privacy Officer. We will require you to submit your request in writing and to provide an explanation concerning the reason for your request.

Right to an accounting of disclosures: You may request an accounting of disclosures, if any, we have made related to your medical information, except for information we used for treatment, payment, or health care operational purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosures made for a specific time period no longer than six years, please submit your request in writing to the privacy officer. We will notify you of the cost involved in preparing this list.

Right to release or request restrictions on uses and disclosures of your health information: You may consent in writing to release your records to others. You have the right to revoke this authorization, in writing, at any time. However, a revocation is not valid to the extent that we acted in reliance on such authorization. You have the right to ask for restrictions on certain uses and disclosures of your health information. This request must be in writing and submitted to our Privacy Officer. However, we are not required to agree to such a request.

Right to complain: If you believe your privacy rights have been violated, please contact us personally, and discuss your concerns. If you are not satisfied with the outcome, you may file a written complaint with the U.S. Department of Health and Human Services 200 Independence Ave. S.W., Washington, D.C. 20201 or 877-696-6775. An individual will not be retaliated against for filing such a complaint.

Right to receive a copy of this and any changes in policy: You have the right to receive a copy oy this document and any future policy changes secondary to changes in state and federal laws. This can be obtained from the Privacy Officer.
Clinical records, psychotherapy notes and other disclosures require a separate signed release of information. You have a right to or will receive notification of a breach of any unsecured personal health information. You have a right to restrict any disclosure of personal health information where you have paid for services out-of-pocket and in full.