Fox Bend Counseling
123 West Washington Street
Suite 321 Oswego, IL 60543
Ph: 630-383-2077/Fax: 630-383-2076

CLIENT INFORMATION

Today's Date:

First Name: Middle Initial: Last:

Address:

City, State, Zip:

Social Security Number: Sex: Date of Birth:

Relationship Status: **(CHECK ONE)**

Telephone Number:

Secondary Phone Number:

Email Address:

I agree and give consent to be reached by for appointment reminders. **(SELECT ONE)**

AUTHORIZATION

I authorize the release of any medical or other information necessary to process my claim. I also request payment of government/insurance benefits to Fox Bend Counseling (FBC) for services provided.

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different from the patient, please complete and sign:

Guarantor Name: Date of Birth:

Address: City, State, Zip:

Guarantor's Phone number: Guarantor's Social Security

Employer Name: Employer Phone:

Employer Address:

Relationship to the patient: Email Address:

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature: Date:

PRIMARY INSURANCE INFORMATION

Insurance Company:

Policy ID#: Group #:

Employer Name: Employer Phone#:

Insured's Name:

Insured's SS#: Insured's Birthdate:

Insured's Address: City, State, Zip:

Patient's Relationship to the insured: (**SELECT ONE**)

SECONDARY INSURANCE INFORMATION

Insurance Company:

Policy ID#: Group #:

Employer Name: Employer Phone#:

Insured's Name:

Insured's SS#: Insured's Birthdate:

Insured's Address: City, State, Zip:

Patient's Relationship to the insured: (**SELECT ONE**)

OFFICE POLICIES

Confidentiality:

- Information in your sessions is confidential EXCEPT if you are threatening to hurt yourself or someone else, or if you tell of a child or an elderly person being abused. In any of these cases, the clinician will have to act upon this information to protect your or someone else.

Appointments:

- There is a 24 hour cancellation fee. When you schedule, the clinician reserves that time for you and if you cannot attend a session, 24 hours' notice must be given or you will be charged a$100.00 fee. This fee is not payable by insurance and MUST be paid by the patient before any future appointments can be made. After 2 consecutive no shows, the patient could be terminated from the office.
- The initial visit is considered to be an evaluation only and not a guarantee that treatment will be the result of said visit. This includes the prescribing of medication.
- If you are scheduled for a medication management appointment with a psychiatrist, you understand that you are required to be on time. If you are late, you understand that you will be required to reschedule the appointment.

Medication Refills:

- All requests for prescription refills must be made **at least 3 business days** before you run out of medication. All refill requests must come from the pharmacy except those for Schedule II medications. Refills for those medications must be left for the office by dialing 630-383-2077 and leaving ALL of the required information. The psychiatrist may require you to be seen before refilling a prescription. Under NO circumstances will medication be refilled early.

Payments and Billing:

- Payment is expected at the time of service unless other arrangements have been made. If health insurance covers your sessions, Fox Bend Counseling will help to seek reimbursement for the insurance company. ANY unpaid balance after insurance is YOUR responsibility to pay.
- It is your responsibility to inform our office if your insurance coverage changes within a timely matter. If your insurance company does not pay within a certain time limit, the professional fees are due and payable in full from the patient.
- If you do not pay your account balance, it may be turned over to collections. In that case, you will be charged an additional 33.33% finance fee.
- In the event that any check you write is retuned NSF (insufficient funds) you agree to pay a $30.00 service fee and any future payments must be made by cash or credit card.
- The parent accompanying the child to the session is responsible for any payment unless other arrangements have been made through the billing department.

Paperwork and Miscellaneous Forms:

- All paperwork is completed at an appointment and a fee up to $100.00 will be assessed by the provider completing the forms and must be paid in advance by the patient.

Conduct:

- We have **ZERO** tolerance policy for any patient who behaves inappropriately to clinical staff and will be discharged immediately. Examples are cursing, violence, verbal threats, sexual inappropriateness, etc.

By signing below, I agree to the terms and conditions of this form.

Signature: Date:

CONSENT FOR TREATMENT

I have chosen to receive mental health services in the form of mental treatment for myself and/or my child from Fox Bend Counseling. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services:

I understand that during treatment I may need to discuss material of an upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with Treatment Plan:

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision:

I understand there are certain circumstances which may require Fox Bend Counseling provider(s) to receive supervision. These circumstances include, but are not limited to the following:

1. State licensure regulations may require my therapist or service provider to receive ongoing supervision.
2. Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed.
3. The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others.
4. Other special circumstances, such as preparation to testify in court.

Client Rights:

- The right to be treated with dignity and respect by all staff.
- The right to be involved in the planning and/or revision of my treatment plan.
- The right to know about my treatment progress or lack thereof.
- The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used.
- The right to be spoken to in a language that is fully understood.
- The right to a clean and safe environment.
- The right to refuse to be videotaped, audio recorded, or photographed.
- The right to end treatment at any time unless court ordered.
- The right to file a complaint or grievance about the agency or staff.
- The right to confidentiality of clinical records or personal information according to federal and state laws.

Emergencies:

I understand I may reach my Fox Bend Counseling provider at 630-383-2077. If not available, I can leave a message for **nonemergency** calls and my call will be returned as soon as possible. If I have a life threatening emergency, I may call 911 or go to the nearest Emergency Room.

I have read, discussed and understood all of the above.

Print Name: Date:

Signature of patient or responsible party if minor:

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Name: Date: Date of Birth:

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between your FBC psychiatrist/therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire one (1) year from the date of signature, unless another date specified.

I,

Patient/Client (PRINT NAME) Date of Birth Social Security #

Please check one:

- ☐ I AGREE to release mental health/substance abuse information to my Primary Care Physician.
- ☐ I DO NOT give my consent to release any information to my Primary Care Physician.

Physician Name:

Physician Address:

Physician Phone: Fax:

Signature of Patient: Date:

Signature of Parent/Guardian: Date:

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CREDIT CARD AGREEMENT

Maximum charge amount: $250.00

Effective date: 01/01/2019

Expiration date: 01/01/2020

I agree to allow Fox Bend Counseling to charge my credit card for any amount (up to maximum amount of $250.00) after a period of 60 days or two billing cycles when a payment has not been made. I acknowledge that:

- My credit card will be charged upon review of the final explanation of benefits from each applicable insurance company for services provided while this agreement is in effect.
- Once a total of $250.00 has been charged to my credit card under this agreement, Fox Bend Counseling which will bill me directly for any amounts not covered by insurance.
- My credit card will be stored by a secure credit card processor affiliated with Fox Bend Counseling to collect payments.
- I may cancel this agreement at any time by contacting Fox Bend Counseling; any unpaid amounts relating to services provided while this agreement is in effect that are not covered by insurance will then be paid in full upon cancelling this agreement.

Credit Card Type: Vis____ MC_____ Discover_____ Amex_____

Card#

Exp. Date / Security Code:

I understand the above listed financial policy and agree to abide by this agreement. My signature serves as authorization to charge my credit card.

Signature Date

Patient or Parent/Guardian if patient is a minor.

Fox Bend Counseling

NOTTCE OF PRIVACY PRACTICES (NPP) - SHORT VERSION

This notice describes how your medical information may be used and disclosed and how you may access this information.

Our commitment to your privacy: Our practice ls dedicated to maintaining the privacy of your personal health information. We are also required by law to do this. This is a shorter version of the full, legally required NPP, which you received along with this so refer to it for more information. If you have questions or concerns about the privacy of your information, please contact our Privacy Officer (see the end of this pamphlet).

We use information about your health, which we get from you or from others, for treatment, to arrange payment for our services, or for other business activities referred to as health care operations. At the end of this NPP ls a Consent Form to be signed allowing us to use and share your information. If you do not consent and sign this form, we cannot treat you.

For treatment purposes, FBC can use your health information and share it with other professionals who are treating you. For example, FBC may disclose your personal health information to your doctor, at the doctor's request, for treatment by the doctor.

If your information ls to be disclosed (sent, shared, released) for any other purposes, we will discuss this with you and ask you to sign a separate authorization to allow this.

We will keep your health information private, but there are situations when we are required to use or share it; they are described ln the full version of the NPP. Examples of these situations are:

1. A serious threat exists to your health and safety oi the health and safety of others. We only share information with a person or. organization able to prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. When required by a law enforcement official to do so.
4. Workers Compensation and similar benefit programs.

Your rights regarding your health information:

1. You can specify how we communicate with you. For example, you can ask us to call you at home and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell individuals (such as family and friends) who are involved in your care or the payment for your care except if it is against the law, or an emergency.
3. You have the right to look at your health information (such as medical and billing records). You can get a copy of these records but we may charge you. Contact our Privacy officer to arrange how to see your records.
4. If you believe information in your records is incorrect or incomplete, you can ask us to make some changes (called amendments) to your health information. This request must be ln writing and sent to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room, and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way

I hereby acknowledge that I have received a copy of FBC's Notice of Privacy Practices and that I have been given an opportunity to read it. I understand that if I have questions about the Notice or my privacy rights, I can contact the Privacy Officer, Diane Harris at 815-729-7790 ext. 102.

Patient/Client Signature: Date:

Parent/Guardian Signature: Date:

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Psychiatric Intake Form

All information on this form is strictly confidential

Name: Date:

Date of Birth: Primary Care Physician:

Current Therapist/Counselor: Phone Number:

What is the problem(s) you are seeking help for?

Depression

Anxiety

Bipolar

ADHD For Adults

ADHD for Children

Other please specify

List ALL current Psychiatric medications **and how often you take them:** (if none, write none)

Medication Name Total Daily Dosage Estimated Start Date

***List ALL current Medical medications* and how often you take them:** (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

"Please note, these self-rated scales are not a substitute for a psychological or psychiatric evaluation and are not intended to diagnose or treat. They are designed to be used in conjunction with your treatment provider. If you do decide to complete any of the below scales, please review the results with your licensed mental treatment provider. If at any point you feel suicidal, homicidal, are hallucinating or feel that you may be a threat to yourself or others, please call 911 or visit your nearest Hospital Emergency Room

By signing below, I agree that the above information provided is true and accurate.

Patient/Client Signature: Date:

Parent/Guardian Signature: Date:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Mood Disorder Questionnaire (MDQ)

Name:_____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
…you were so irritable that you shouted at people or started fights or arguments?	◯	◯
…you felt much more self-confident than usual?	◯	◯
…you got much less sleep than usual and found you didn't really miss it?	◯	◯
…you were much more talkative or spoke faster than usual?	◯	◯
…thoughts raced through your head or you couldn't slow your mind down?	◯	◯
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
…you had much more energy than usual?	◯	◯
…you were much more active or did many more things than usual?	◯	◯
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
…you were much more interested in sex than usual?	◯	◯
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
…spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these causes you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry*. 2000;157:1873-1875.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name _____ **Today's Date** _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an **X** in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

Part A	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Vanderbilt ADHD Diagnostic Parent Rating Scale

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____

Grade: _____

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

1. Does not pay attention to details or makes careless mistakes, such as in homework	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations when remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes on others (butts into conversations or games)	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to comply with adults' requests or rules	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and vindictive	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Initiates physical fights	0	1	2	3
29. Lies to obtain goods for favors or to avoid obligations ("cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen items of nontrivial value	0	1	2	3
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3

Vanderbilt ADHD Diagnostic Parent Rating Scale

Each rating should be considered in the context of what is appropriate for the age of your child.

Frequency Code: 0 = Never; 1 = Occasionally; 2 = Often; 3 = Very Often

45. Feels lonely, unwanted, or unloved; complains that "no one loves" him or her	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3