amanda atkins
COUNSELING

Today's date:	

CLIENT INFORMATION

Client's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) S / Mar / Partner/ Div /Sep / Wid

Is this your legal name?	Guarantor? Yes No IF No, who will be responsible for bills?	(Former name):	Birth date:	Age:	Gender:
❑ Yes ❑ No			/ /		❑ F ❑ M ❑ Transgender ❑ _____

Street address:	Social Security no.:	phone no.:

Email:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

Referred to by:	❑ Google Search	❑ Psychology Today	❑ Insurance Plan
❑ Family ❑ Friend ❑Yelp	❑Website	❑ Other:	

If engaging in couples therapy:

Partner's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) S / Mar /Partner/Div /Sep / Wid

Is this your legal name?	Relationship to Client:	(Former name):	Birth date:	Age:	Gender:
❑ Yes ❑ No			/ /		❑ F ❑ M ❑ Transgender ❑ _____

Street address (if different):	Social Security no.:	phone no.: ( )

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights & Therapist Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your PHI in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so we can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am **permitted or required** to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.

3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. Where applicable, I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am **legally obligated to take actions**, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Illinois Abuse Hotline. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** If we wish to provide information outside of Amanda Atkins, LLC for your treatment by another health care provider, we will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – We may use and disclose your health information to obtain payment for services we provide to you as delineated in the Therapy Agreement.

- ***For Operations*** – We may use and disclose your health information within Amanda Atkins, LLC as part of our internal operations. For example, this could mean a review of records to assure quality.

Patient's Rights:

- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and we will decide if it is and if we refuse to do so, we will tell you why within 60 days.
- ***Right to a copy of this notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to choose someone to act for you*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; we will make sure the person has this authority and can act for you before we take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I

ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. We will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, the State of Illinois Department of Health, or the Secretary of the U.S. Department of Health and Human Services.

(Please sign the next page)

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YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

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COUNSELING

Financial Agreement and Authorization To Charge Credit Card

- Co-payments are due at the time of service.
- Insurance policies are contracts between you and your insurance company. I file these claims as a courtesy and try to help with problems, but you need to resolve those beyond my control. If insurance is not paying within a reasonable time, you will be responsible for full payment.
- If I am not covered by your insurance company, full payment is due when services are provided.
- Any appointments scheduled but not kept, as well as any appointments cancelled within 24 hours of scheduled time will be charged at the full fee of $75. This is not covered by your insurance company.

Client Name:_____DOB: _____

Name on Credit Card _____

Zip Code of Credit Card Billing Address: _____

Phone Number of Cardholder: _____

Credit Card Number: _____

Expiration Date: _____ Security Code/CVV: _____

- I authorize Amanda Atkins, LLC to charge my card for office charges.
- I understand that if my credit card does not accept the charge, I will immediately make the payment to the practice.
- I understand that I may cancel this authorization at any time, but by doing so, I acknowledge that the balance owing will be due & paid in full.
- I acknowledge that credit card transactions could be linked to Protected Health Information.

_____

Signature of card holder Date

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COUNSELING

Service Agreement & Consent for Treatment:

1. Services. Amanda Atkins, LLC provides individual therapy, couples therapy, and family therapy. Each of these modes of treatment may require involvement from people who are not present at the first session. The terms and modality of the treatment may change based on the treatment needs. These changes will be discussed and agreed upon with the client(s).

2. Confidentiality. All information concerning clients is held confidentially and is released only through procedures consistent with the law and professional ethics. This confidentiality may be broken under the following circumstances:

    a. If child abuse is suspected, the therapist is mandated by the state to report it to the Department of Child and Family Services (DCFS).

    b. If elder abuse is suspected, the therapist is mandated by the state to report to the Office of Elder Abuse.

    c. If a client is reporting that he/she is a danger to him/herself or others, confidentiality may be broken in order to protect the client or the person who is being threatened with harm.

    d. Minors under the age of 12 are given limited confidentiality and do not have to sign a release to have their information given to others. Permission for the release of their information can be granted by an appropriate guardian.

    e. Minors over the age of 12 must give consent for their private information to be released.

    f. Adolescent clients under 18 can have limited confidentiality for individual sessions. This limit is negotiated with the client's family and the therapist. Typically, this confidentiality does not allow for parents restriction from information that could be seriously damaging, life threatening, or impactful to the minor.

    g. Clients using insurance must allow a diagnosis and any other requested information to be released to their insurance company.

    h. Client's involve in the court system must grant permission for the therapist to speak with all necessary parties, GAL's, Child Advocates, Child Representatives, or other representatives as needed. A release of information will be filled out to specify the kind of information to be released.

    i. A court order, signed by a judge, can break confidentiality and require the therapist to open his records to the court.

j. Associates will discuss all of their clinical work with their supervisor each week.

3. Custody and court involvement. In case where families have court involvement, the therapist will not testify to the appropriateness of one parent over the other. The therapist is not evaluating custody for children involved in divorcing families.

4. Fees and Insurance. Fees are expected at the time of service. A guarantor will be identified at the first session and this person will be responsible for all of the session payments. Payments can be made by check, cash or credit card. Credit card information is stored in a secure database and using the credit card for payment indicates that clients agree to this procedure. Billing for BCBS clients is handled by the therapist. Co-pays will be collected at the time of session. Sometimes, BCBS has extra fees that clients are responsible for paying. These fees are often due to co-insurance, deductibles, or other charges not covered by BCBS. These fees will be charged to the client. The client can pay these fees with the credit card on file if they like. The client's session fee is $150. BCBS has a contracted rate that is less than this and BCBS clients will not be responsible for covering the difference between the therapist's fee and the contracted rate.

5. Appointment Cancellation. The therapist requires a 24 hour minimum to cancel appointments. If appointments are not cancelled within 24 hours of the session, the therapist will charge the client for the session. The session fee is $75. BCBS will not pay for missed sessions and the full $75 will be due for missed sessions. Emergencies will be allowed when appropriate.

6. Contacting the Therapist. The therapist is available through phone or email. The therapist's phone number is 312.401.6574, and her email is amanda@amandaatkinschicago.com. Amanda can generally return your call or email on the day of the call, but this is not guaranteed. The therapist does not return calls or emails over the weekend or holidays. In the case of a serious, life-threatening emergency, call 911 for assistance.

7. Case Closing. 120 days after the last session, client's episodes of treatment are considered over and their case is closed. If the client comes back after 120 days, their case is considered re-opened and the guidelines of this agreement will continue with the new episode of treatment.

8. Consent for Treatment. By signing this document you are agreeing to the above terms and consenting for treatment with this therapist. You have been informed of your rights as a client and your responsibilities.

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I have read and received both the notice of privacy practices (HIPPA) and the service agreement.

_____

Signature Date

_____

Signature Date

_____

Signature Date

_____

Signature Date

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Release of Information

Client Name: _____

Date of Birth: _____

I understand by signing this form, I am allowing Amanda Atkins to disclose to and/or obtain information concerning the above named client to:

_____
Name of Person and/or Institution

_____
Mailing Address/Street/P.O. Box City/State/Zip Code

Description of Information to be Disclosed
____Assessment ____Testing Information ____Medication List
____Diagnosis ____Educational Information ____Billing Information
____Psychosocial Evaluation ____Presence/Participation in Treatment
____Psychological Evaluation ____Continuing Care Plan
____Treatment Plan or Summary
____Progress in Treatment ____Other

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:
_____

_____

This release expires on _____.
(month/day/year)

_____
(Signature of Client, Parent, Guardian or Personal Representative) (Date)

Relationship if not the client: _____