



CLIENT REGISTRATION INFORMATION

First Name _____ Last Name _____
Street Address _____ City _____ State _____ Zip _____
Billing Address Same as above See below
Billing Street Address _____ City _____ State _____ Zip _____
E-mail Address _____
Preferred Address for correspondence or statements Billing Address E-mail Address _____
Birth Date _____ Age _____ Social Security # _____
If minor (under age 18) please write name of legal guardian _____
Employer/School _____
Employer/School Address _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Phone _____ Cell Phone _____
How late can calls be returned? _____
Referred by _____ Relationship to insured: Self Spouse Child Other
Marital Status: Single Married Widowed Divorced Other
Employment Status: Employed Full-time Student Part-time Student

POLICY HOLDER/GUARDIAN'S INFORMATION (if different from above)

First Name _____ Last Name _____
Street Address _____ City _____ State _____ Zip _____
Birth Date _____ Age _____ Social Security # _____
Employer/School _____
Home Phone _____ Work Phone _____
Caseworker's Name _____ Phone _____

PRIMARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____
Insured's ID # _____ Group/Policy # _____ Agency/Insurance _____
Phone _____ Insurance Claims Mailing Address _____
City _____ State _____ Zip _____
Subscriber Name _____ Subscriber Date of Birth _____
Co-pay amount _____ Authorization # _____ Number of Sessions Authorized _____

Secondary Insurance No Yes – Complete Secondary Insurance Information Form

A copy of your insurance card and photo ID is needed at the time of service. Please read the following carefully and sign below.

Assignment of Benefits and Release of Information

I give permission to Better Balance Counseling, Ltd and billing staff to send required information to my insurance company or my Employee Assistance Program (EAP). I am aware that I am placing my signature on file and that this authorization shall remain valid until written notice is given by me revoking said authorization. I also understand that I will responsible for any unpaid balances including copayments, deductibles and non-covered services. I understand that appointments missed or cancelled less than 24 hours before the appointment will be billed at 100%. I understand that my insurance or EAP does not cover the cost of missed sessions.

Signature of responsible party

Date

SECONDARY AGENCY/INSURANCE INFORMATION (if applicable)

Agency/Insurance Carrier Name _____

Insured's ID # _____ Group/Policy # _____ Agency/Insurance _____

Phone Insurance Claims Mailing Address _____

City _____ State _____ Zip _____

Subscriber Name _____ Subscriber Date of Birth _____

Co-pay amount _____ Authorization # _____ Number of Sessions Authorized _____

Secondary Insurance ___No ___Yes – Complete Secondary Insurance Information Form

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Signature of responsible party

Date

BRIEF ASSESSMENT

Please list presenting issues and length of time you have been experiencing them: _____

SYMPTOM CHECKLIST

Check all that apply

	NONE	MILD	MODERATE	SEVERE
aggressive behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
appetite changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
believe someone is watching you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
bingeing/purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
conduct problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
crying/tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
depressed mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dissociative states	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
elevated mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fatigue/low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
emotional trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
feeling sadness/emptiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
general anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hearing voices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
loss of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
need to repeat actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
obsessions/compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
post traumatic stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
racing thoughts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
self-harming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sexual issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
social isolation/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
substance abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
thoughts of death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
worry/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BRIEF HISTORY

EMOTIONAL/PSYCHIATRIC HISTORY

Have you previously had counseling services? If yes, please provide the following information:

How many visits did you have? _____ Provider Name: _____

What was the presenting issue? _____

Have any of your family members been in treatment to your knowledge? If so, what was the reason(s)? _____

Have you previously had inpatient treatment or hospitalization for a psychiatric, emotional or substance use disorder? If yes, please provide the following information:

How many occasions? _____ How long were you hospitalized? _____

Dates: from ___/___ to ___/___ Facility name: _____
month/year month/year

Are you currently prescribed any psychotropic medications? If so, please provide the following information:

Medication	Dosage	Frequency	Start date	Side Effects	Beneficial?
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_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____
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FAMILY INFORMATION (feel free to add information below or on the back of this sheet)

Marital status? _____

Children? Please provide ages: _____

Briefly describe your relationships within your family? How do you perceive your role? _____

Parents: Describe your present and childhood relationship with them _____

Siblings: How many? Gender/age and describe present and childhood relationship with them:

Other significant relationships you may like to provide information about: _____

Special circumstances in childhood? _____

Have you suffered any abuse or trauma? _____

Notice of Privacy Practices

This Notice describes how Medical Information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the ACA Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Better Balance Counseling, Ltd is required to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. Better Balance Counseling, Ltd is required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will Be effective for all PHI that we maintain at that time. Better Balance Counseling, Ltd will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

How we may use and disclose Health Information about you.

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard, the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We may use PHI to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health

and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations (such as the social work licensing board or the health department).
- Required by Court Order.
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Better Balance Counseling, Ltd 7627 W Lake St STE 213 River Forest, IL 60305.

Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.

- **Right to Amend.** If you feel that the PHI Better Balance Counseling, Ltd has about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12- month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Better Balance Counseling, Ltd, 7627 W Lake St STE 213 River Forest, IL 60305 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W.

Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Client Name: _____

Date of Birth: ____/____/____

Social Security Number: _____ - _____ - _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Better Balance Counseling, Ltd Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Better Balance Counseling, Ltd at (708) 516-5373 or hillary.pilotto@gmail.com

Client Signature: _____

Date: ____/____/____

Parent, Guardian or Personal Representative Signature*:

Date: ____/____/____

*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

_____ Client Refuses to Acknowledge Receipt

Signature of Witness: _____

Date: ____/____/____

WHAT TO EXPECT FROM SERVICES

Hours and cancellation:

Office hours vary throughout the week. If you need to call to change an appointment time, feel free to leave a voicemail. If it becomes impossible for you keep an appointment, please be sure to cancel with more than 24 hrs notice. Appointments that have not been cancelled will be charged \$100.

Fees and Insurance:

Charges for psychotherapy sessions are consistent with standard psychotherapy fees in our community. Payment is requested at time of services.

Any specific questions about your insurance or billing can be discussed with me. Fees not paid will be sent to collections. If you have any concerns about your bill or payments, please discuss with me immediately.

If, for some reason, a claim is denied or not paid for any reason during treatment or after, the client is fully responsible for the payment of services.

Emergencies:

In the event of an emergency, you may attempt to contact me via cell phone (708) 516-5373. However, I may be in a session or not immediately available. If you are in an emergency situation, please call your local crisis line, 911, or proceed to your local emergency room.

Confidentiality:

A commitment is made to make this a safe and comfortable place for you to receive counseling services. To that end, adherence to all legal protections of your confidentiality will be assured. Limitations include life-threatening behavior, child abuse, elder abuse and judge's orders to release information. Good communication is vital so please report any problems that may arise during the course of services. Please do not hesitate to ask for clarification as needed.

I have read and agree to the above items:

Client signature

date

Provider signature

date

Authorization for Release of Confidential Health Information

I, _____, hereby authorize Better Balance Counseling, Ltd
(Name of Client or Authorized Agent)
to release to/or secure from:

(Name of Health Care Facility, Physician, Agency etc.)

(Street Address, City, State and Zip Code)

The following information contained in the client record of

(Client's Name) Born: ___ / ___ / ___

To be disclosed, the following items must specifically be checked:

- Account Information
- Office Psychotherapy Notes Psychological Testing Report
- Treatment Summary
- Verbal Discussion of Case
- Other (specify): _____

The purpose(s) of the authorization is (are):

- At the request of the individual
- Coordination of Mental Health Treatment
- Payment of Account
- Other (specify): _____

I understand that the practice may not condition treatment on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by law.

I understand that I may be responsible for the cost of medical record copying service.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the practice of my desire to do so. I also understand that I will not be able to revoke this

authorization in cases where the therapist has already relied on it to use or disclose my health information. Written revocation must be sent to the practice. Absent such written revocation, this Authorization for Release of Confidential Health Information will terminate on _____.
(Date)

Signature of Client** Date: ____/____/____

Signature of Witness

Signature of Parent or Guardian

**Client signature is required in addition to the parent or guardian signature for clients ages 12-17.

Notice Regarding Confidentiality of Emails and Text messaging

I cannot guarantee that your employer or others within your home will not have access to personal email communications and text messages. Before permitting this as a means of communication with our office you should make an inquiry as to the level of privacy protection that any such communications will have.

To better facilitate this caution please inform me of the preferred means and manner of communication, and whether you would have any concerns about potential confidentiality leaks. For example, although many employees may be aware that accessing their personal email via a work computer might potentially allow the employer to view their personal email, you may not be aware that accessing your personal electronic messages via an employer-provided smartphone might raise similar issues. Text messaging may raise comparable concerns.

Employer-provided computers, systems and smartphones are not the only concern here. Even where you access personal email on a personal smartphone or home computer, there may be issues of access by other third parties, such as family members, particularly in cases such as divorces or will contests. Other problems may arise with the use of hotel or library computers as well.

Part of my duty to a client is to educate you about the nuances of the counselor-client relationship and the obligations of both counselor and client to preserve that confidentiality.

Please note your election whether and in what manner you do or do not wish to receive and transmit messages by electronic means:

1. I do/do not agree to the use of email for communications at the following email address: _____.

2. I. I do/do not agree to the use of text messaging at the following phone number _____

Client: _____ Date: _____

CREDIT CARD AUTHORIZATION FORM

Please note that the information on this form will be securely entered and stored in a HIPAA compliant on-line virtual terminal that is password protected for your safety. Once your information has been entered to the secured terminal, these paper forms will be shredded and destroyed immediately to protect your information. While all secure methods to protect your information are in place, and we take your safety seriously, no company can 100% guarantee that any on-line system cannot be breached, thus you are accepting responsibility and risk in allowing Better Balance Counseling, Ltd to store your information for therapy charges. I authorize Better Balance Counseling, Ltd to keep my signature and card information on a virtual terminal file that is password protected and HIPAA compliant in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVD's, CD's, and other materials, and or fees), or for any appointments with my therapist that are not cancelled 24 hours before the scheduled appointment time to be charged to my credit, charge, or debit card as filled out below for therapy services provided to:

(Client name – Please print)

I understand that this authorization is valid until canceled in writing. I understand that though this information is secured in on-line protected client file, and is unlikely to be tampered with, I agree to assume the risk if the file and credit card information is compromised. I understand that charges for on-going services or materials will normally be posted to my credit/debit/flex card account within 48 hours of each session date.

Additionally, I agree that the card listed below may be charged by my therapist with Better Balance Counseling, Ltd in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials [i.e. books, CD's, DVD's] that I have not returned within one week of termination. I understand that if a charge back fee is incurred or a retrieval fee of is incurred I am responsible for these fees.

Initial ____ I agree that if I have any concerns or questions regarding charges to my account, or if the charge fails to post to my account, I will contact Better Balance Counseling, Ltd for assistance and/or disclosure. I agree that I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with my therapist and those attempts have failed. Initial ____ 2 Further, if I am assuming session payment responsibility for the client above whose name is listed in the printed area, and that client is someone other than myself, I understand that I am not entitled to information pertaining to confidential therapy sessions as provided by this persons at Better Balance Counseling, Ltd. Initial ____ By initialing this box, I agree to have my card on file and charged the balance after each session. This includes any session fees, co-payments, co-insurance or deductibles. Initial ____ I understand and agree to these terms. I understand the conditions of this payment policy and agree to the conditions stated above:

Cardholder Name [print]: _____

Signature _____

Relationship to client: _____

Billing Address: _____

Zip Code: _____

Number: _____ - _____ - _____ - _____ Exp. Date: _____

CVV Code (3-digit code on back of card): _____

I understand that therapy sessions for the client will be charged via this payment form unless otherwise discussed with my therapist: Cardholder Signature:

_____ Date: _____