PAMELA RAK, LCSW, P.C.

INTAKE FORM

(Please print clearly)

Name: _____ Date of Birth: ____/____/_____ Age: _____

Address: _____ Phone: (Home) _____

_____ (Work) _____

_____ (Cell) _____

Email Address: _____@_____

Emergency Contact Person: _____Phone number: _____Relationship: _____

Marital Status: Single Married Divorced Separated

Children's Names	Age	Health
_____	_____	☐ Excellent ☐ Good ☐ Other _____
_____	_____	☐ Excellent ☐ Good ☐ Other _____
_____	_____	☐ Excellent ☐ Good ☐ Other _____
_____	_____	☐ Excellent ☐ Good ☐ Other _____

Highest Level of Education Achieved: _____

Employer: _____ Occupation: _____

How did you hear about my practice: _____

Last time you visited your primary physician: _____

Physician Name: _____ Phone: _____

Address: _____

Do you participate in regular health screenings? _____

Other Medical Professional(s) you are receiving care from at this time:

Name: _____ Phone: _____

Name: _____ Phone: _____

Describe any medical problems, conditions or diseases for which you are being treated:

_____
_____
_____

Current Medication (s)/herbs/vitamins **Dose/Dosing** **Prescribing Physician**

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____
4. _____ _____ _____

List any history of serious illness in your family:

_____
_____
_____

List family members who have mental illness and describe their condition:

1. _____
2. _____
3. _____

Please describe your spirituality/faith/belief system:

_____

Have you ever been in counseling before? Yes ___ No ___
Have you ever been hospitalized for psychiatric reasons? Yes ___ No ___
*If yes to either question, please describe your most recent experience to include name(s) of therapists and date(s):*_____
_____

Have you ever attempted suicide? Yes ___ No ___
Are you homicidal or suicidal now? Yes ___ No ___

Please quantify how much alcohol do you consume per week? _____

Is there a history of alcohol or other substance abuse in your family of origin? _____

What illegal substances do you/have you used and indicate if recently and/or in the past?

_____

What are your reasons for coming for treatment with me at this time?

_____
_____
_____

Thank you

Treating Practice Information

Pamela Rak, LCSW PC (847) 776-1594
2500 W. Higgins Road Atrium II Suite 1131
Hoffman Estates, Illinois 60169

Authorization to Release Mental/Behavioral Health Information

Patient Name:_____ Date of Birth: _____-_____-_____
Street Address:_____
City, State, Zip: _____

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

PCP/Medical (Includes Specialty Practice Professionals), Behavioral Health Clinician/Facility

This section to be completed by the patient

Professional's Name: _____
Address: _____ Phone: _____

Professional's Name: _____
Address: _____ Phone: _____

Patient Clinical Information

This Section to be filled out by Clinician

:

The patient is taking the following prescribed psychotropic medication/s:

_____
_____

The patient is being treated for: _____
Expected Length of treatment: □ <3 months □ 3-6 months □ 6-12 months □ > 1 year

Coordination of care issues/other significant information impacting medical or behavioral healthcare:

_____
_____
_____

I hereby freely, voluntarily and without coercion, authorize Pamela Rak LCSW PC to release the information contained on this form to the physician/clinician/facility listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. I understand I may revoke my consent at any time and it must be in writing.

Patient Signature Date
_____ _____/_____/_____

Clinician Signature
_____ _____/_____/_____

Pamela Rak, LCSW PC, (847) 776-1594
Atrium II Suite 1131 2500 W. Higgins Road
Hoffman Estates, Illinois 60169

AGREEMENT FOR SERVICES

Thank you for choosing Pamela Rak, LCSW PC for your professional mental/ behavioral health and counseling services. The following are the provider's treatment contract. By initialing and signing I indicate my understanding and agreement to the terms of this Agreement. This document is also intended to inform you of the policies, State and Federal Laws, and your rights.

Consents and Authorizations:

I have the legal right to authorize and I hereby consent for services for myself and/or my dependent(s) with Pamela Rak, LCSW PC which may include evaluation, group therapy, referral for psychiatric evaluation, referral to a physician, or psychological testing.

I authorize communication, consultation, and exchange of information verbally, electronically, and written with professional counselors, therapists, physicians, clergy, legal representation, specialty practice physician, hospital, and, psychiatrists as is pertinent to my care and treatment. This authorization is extended to any and all referrals Pamela Rak, LCSW PC recommends for consultation, on-going treatment, and care and insurance company should billing be against benefits.

I understand that appointments are by schedule only and therapy sessions are generally 45-60 minutes in length. If I choose to reschedule or cancel an appointment, I must provide Pamela Rak, LCSW PC a minimum of 24 hours advance notice. Due to the demand for appointments if I do not provide proper advance notification, I will be charged the full session fee with payment due by two weeks' time. I understand that insurance companies DO NOT pay for missed appointments or late cancellations. If a credit card has been placed on file, I understand, agree to, and authorize the card on file to be charged against the appointment.

I understand that follow up treatment may be required to maintain ongoing quality care. Lack of follow-up for over 3 months will automatically result in my file being made inactive with the practice and may require a new evaluation.

If a physician has made the referral, a letter will be sent to the doctor indicating that I kept the appointment and am receiving counseling services including diagnosis, pertinent data, and treatment recommendations.

I understand Pamela Rak LCSW PC may refer me to clinicians or services outside of the practice should she determine she cannot provide the necessary treatment needed to effectively and ethically treat me.

I understand Pamela Rak, LCW PC does not use e mail or texting as methods to communicate clinical information, urgent information or other treatment related issues regardless of time-sensitivity. I understand that I must contact Pamela Rak, LCSW PC by phone for all patient clinical and urgent or administrative concerns. Texting and e mail are only permitted for the purposes of scheduling or rescheduling an appointment.

I have received a copy of Pamela Rak, LCSW PC Notice of Privacy Practices and understand and agree to my responsibilities as a client/patient receiving professional services.

Pamela Rak, LCSW PC may be required by law to release information without my approval to legal authorities if:

- There is clear and serious danger of harm to myself or anyone
- A judge requires specific information in a court case
- It is suspected that a criminal offense of elder or child abuse or neglect has occurred

I understand limited phone contact is acceptable, however, any conversation lasting longer than 10 minutes is considered a counseling session and I will be billed in fifteen-minute increments. Insurance companies do not traditionally reimburse for such services and the rate of $60.00 dollars per quarter hour will be charged to me.

Continued>>>>>>>>>>>>>>>>>>>>>>>

Payment for Services:

Fees are set within the usual and customary range for this community. If services qualify for insurance reimbursement, Authorization (if required) and payment for services is expected at the time of each visit (payable by cash, credit card, check or HSA card). Photocopy of any insurance card(s) shall serve as authorization for billing against any benefits. This document also serves as consent to access the eligibility and benefits, claims and authorization information and to submit claims in the most expeditious method. Failure to obtain the necessary authorizations from insurance companies will result in the client/patient paying all session fees. I agree to inform Pamela Rak, LCSW PC of any contract or insurance information changes promptly.

I have completed the demographic and any insurance information on the Intake Form to the best of my knowledge and authorize Pamela Rak LCSW PC to release any medical information (including types of services, dates/times of services, diagnosis along with treatment plans, progress of treatment, case notes and summaries (if necessary) to process my insurance claim(s).
Should an outstanding account become delinquent (30 days unpaid with last date of session as beginning count) Pamela Rak, LCSW PC reserves the right to use the credit card provided on file to apply the balance on the 30th day. A service fee of $35.00 dollars will be charged for each returned check. The credit card on file may also be used for this purpose.

If you are engaged in court litigation you agree that Pamela Rak, LCSW PC will not be subpoenaed for testimony.

Mental Behavioral Health Counseling

Mental Health Behavioral Counseling is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems. There are many different methods I may use to help you with the problems that you hope to address. Counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the counseling to be most successful, you may benefit from working on things we talk about both during our sessions and at home. Counseling sessions will typically be on a weekly or bi-weekly basis. Additional appointment times can be arranged on an as-needed basis. While every effort is made to remain on time an extended five or ten minutes may be necessary on some occasions and your understanding should appointments run over is greatly appreciated. Every appointment session "clinical hour" will be honored. Counseling can have benefits and risks. Since counseling often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, counseling has also been shown to benefit people by leading them to better relationships, solutions to specific problems and significant reductions in feelings of distress. There are no guarantees of what you will experience.

I have read and understand the above information and I understand and agree to each and all its contents. I hereby acknowledge that I have received and have been given an opportunity to read a copy of Pamela Rak, LCSW PC Notice of Privacy Practices. My signature indicates y consent to receive treatment with Pamela Rak, LCSW PC. This consent can be revoked at any time in writing.

Print name: _____ Date: _____

Signature: _____ Date: _____

Individual Patient's Authorization HIPAA

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below.

Individual Patient's Name _____ Date of Birth _____/_____/_____

Your Address _____

Home Telephone Number _____ Cell Phone Number _____

2. THE USE AND/OR DISCLOSURE AUTHORIZATION

Protected health information you are authorizing to be used and/or disclosed may include:

CONTACT INFORMATION, COUNSELING AND PSYCHOTHERAPY NOTES,
CLINICAL IMPRESSION, INSURANCE INFORMATION, DIAGNOSIS

The people and/or organizations (or the kind of people and/or organizations) that you are authorizing to use, exchange and/or to disclose the protected health information described above for continuity of care and business operations:

Insurance Company to include submitting e claims and verbal/written communication re: EOB and Claims
Primary Care Physician
Consulting Physician(s), Pediatrician(s) and Medical and Mental Health Professionals
Employee Assistance Program
Referring professional to include legal representation, clergy, etc.

3. ENDING THIS AUTHORIZATION

___ This authorization will end on the following date: _____

XX This authorization will end when the following event happens. (The event must relate to the individual or the purpose of the authorization use and/or disclosure): Termination of care**.**

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy. Pamela Rak, LCSW PC also may expect payment from me and may use the credit card on file to resolve any/all outstanding charges I incur.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrolment and eligibility determinations.

6. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by singing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form. I give this permission voluntarily.

Signature _____ Date: _____

Print Name: _____

YOU HAVE A RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Pamela RAK LCSW, PC
Atrium II, Suite 1131
2500 W. Higgins Road
Hoffman Estates, Illinois 60169

CREDIT CARD AUTHORIZATION

Client Name: _____
(please print)
Address: _____ City/State: _____ Zip Code: _____

Credit Card #: _____

V Code Identifier: _____

Credit Card Type (MC, VISA, DISCOVER, H.S.A., AMEX, etc): _____

Expiration Date: Month _____ Year _____

Name as it appears on card (please print): _____

Signature of cardholder: _____

PLEASE INITIAL:

_____ I authorize Pamela Rak LCSW PC to process my credit card for all charges due for services rendered.

Signature: _____ Date: _____