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?

_____
_____
_____

PAMELA RAK LCSW PC 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

Describe in detail the protected health information you are authorizing to be used and/or disclosed:

COUNSELING AND PSYCHOTHERAPY NOTES
VERBAL, WRITTEN, AND, E MAIL COMMUNICATION

Name the Consulting Physician(s), Pediatrician(s) and Medical and Mental Health Professionals 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:

Name: _____ License Number: _____ NPI: _____
Practice Name: _____ Practice Address: _____
Phone: _____ E Mail Address: _____

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, exchange, 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: _____

If this authorization is signed by a representative for the individual patient:

Print Name: _____

Signature _____ Relationship to individual patient: _____

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

Court Related Exchange and/or Release of Information Form

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

Referring professional/office _____
Address: _____ City: _____ Zip Code: _____
Phone: _____ Email: _____ Fax: _____

I _____ understand my attorney/The Court has made this referral and a
(please print your name)
letter may be sent to the attorney/The Court that I am/my children are receiving counseling/coaching services.

If you are engaged in court litigation, you agree that Pamela Rak, LCSW PC will not be subpoenaed for testimony. If appropriate and with *Release*, Pamela Rak, LCSW may draft a treatment summary for your attorney/The Court.

Email and text messaging are available for communication with Pamela Rak, LCSW PC, however:
-using these methods, I acknowledge that my privacy may be compromised
-text messaging is only to be used for appointment scheduling or appointment confirmation
-email may be used for limited treatment-related issued and you acknowledge immediate response is not guaranteed.

On those occasions when parents are seeking professional counseling services related to any/all separation and divorce decisions, neither parent will contact Pamela Rak, LCSW PC independently save for circumstances involving clear and present danger of harm to anyone.

Services such as coaching, mediation, and conflict management services are fee for service basis only. Additionally, fees are dependent on the scope and nature of the services to be provided. Payment in full is expected at the time of each visit using check, cash, credit/debit card. If you are unable to attend an appointment, I request that you provide at least 24 hours advanced notice to my office. For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be charged for the full session fee.

By signing this document I agree to Hold Harmless Pamela Rak, LCSW PC from the responsibility for any liability or damage that might arise out of the services provided.

I hereby freely, voluntarily and without coercion, authorize Pamela Rak LCSW PC to release information pertinent to my case to the professional/professional office listed above; the reason for disclosure is to facilitate continuity and coordination. I understand I may revoke my consent at any time with written notification.

_____ _____/_____/_____
Signature: Date

_____ _____/_____/_____
Pamela Rak, LCSW PC Date

Pamela Rak, LCSW PC (847) 776-1594 www.pamelaraklcsw.com
Atrium II Suite 1130 2500 W. Higgins Road
Hoffman Estates, Illinois 60169

AGREEMENT FOR SERVICES

Thank you for choosing Pamela Rak, LCSW PC (Pamela Rak also in Agreement) for your professional divorce coaching, co-parenting, and divorce counseling services. The following is the provider's treatment contract. By initialing and signing you indicate 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 hereby consent for services for myself with Pamela Rak. Services may include but not be limited to evaluation, treatment recommendation, collateral work with other professionals (ie. 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 with ***Release of Information*** specifying the professional(s) with whom information will be exchanged.

I understand that hours are by appointment only and sessions are 50-60 minutes in length. Coaching and Co-parenting appointments and consultation will be determined on a case by case basis. If I choose to reschedule or cancel an appointment, I must provide Pamela Rak the 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 in two weeks' time. 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 case being made inactive with the practice and may require a new evaluation.

If an attorney/The Court has made the referral, a letter will be sent to the referring professional indicating that I kept the appointment and am receiving services.

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

I understand Pamela Rak 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 permitted when scheduling or rescheduling an appointment. 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 and the rate of $60.00 dollars per quarter hour will be charged to me.

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

- 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

Payment for Services:

Fees are set within the usual and customary range for this community. Payment for services is expected at the time of each visit (payable by cash, credit card, or check).

Insurance companies frequently do not pay for Divorce Coaching, Co-Parenting consultation, and Divorce Counseling, meetings with legal counsel, document preparation, or court time. If you are engaged in court litigation you agree that Pamela Rak, LCSW PC will not be subpoenaed for testimony.

If you choose to have your insurance company be aware of your treatment, you agree to Hold Harmless Pamela Rak, LCSW PC for any repercussions for claim submission. Photocopy of the insurance cards 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 by 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.

Fees Schedule:

Fees are applied to the time I spend on your behalf, whether it is with you individually, with your co-parent partner, in a meeting with you and your attorney(s) or conferring with your attorney(s) as appropriate. Examples of professional time for which you will be billed include: telephone calls, meeting and travel time, and, correspondence (including e mail communication). Payment is accepted in cash, check, or credit card. Detail of expenses and charges is available upon request with fee per hour set as $180.00.

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 my consent to receive treatment with Pamela Rak, LCSW PC. This consent can be revoked at any time in writing.

Print name: _____ Date: _____

Signature: _____

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

CREDIT CARD AUTHORIZATION

Client Name: _____

Address: _____ City/State _____Zip Code: _____

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

V Code Identifier: _____

Expiration Date: Month: _____ Year: _____

Name as it appears on card: _____

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: _____