Sanders & ASSOCIATES
Provides quality mental health services in a safe, nurturing and confidential environment.

## CLIENT INFORMATION

Name: _____ Male ☐ Female ☐

Your Date of Birth: ___/___/____ SS# _____

Mailing Address: _____

City: _____ State:_____ Zip Code:_____

Home phone: ____-____-_____ Work phone: ____-____-_____

Cell phone: ____-____-_____ May we text you? Yes ☐ No ☐

Email Address: _____

Who referred you to Sanders & Associates? _____

Why are you seeking assessment or treatment? _____

_____

## INSURANCE INFORMATION

Name of policy holder/insured _____

Date of birth of policy holder/insured ___/___/____

Insured's address and phone number (if different than patients) _____

_____

Insurance Company _____

Member ID # _____

Group Number _____

Insurance Company's phone number ____-____-_____

Claim Address _____

_____

# MEDICAL HISTORY

*This information will us serve better. Please complete each section in its entirety.*

Family History of Mental Illness, Suicide? Yes ☐ No ☐

If yes, briefly explain: _____

_____

Medications You are Currently Taking (Include supplements and over the counter drugs)

| Name of Medication | Dosage | Taken for… |
|---|---|---|
| 1. | 1. | 1. |
| 2. | 2. | 2. |
| 3. | 3. | 3. |
| 4. | 4. | 4. |

Family History of Alcohol or Drug Abuse? Alcohol Yes ☐ No ☐

Drug Abuse Yes ☐ No ☐

Please list any past/present drug and alcohol use. What have you used and how much? What are you currently using and how much. Has it ever affected your working or your relationship?

Do you have any previous suicide attempts, self-destructive behaviors, or violent behaviors? (Indicate age, circumstances, and whether it led to hospitalization or legal problems).

Have you ever been hospitalized? (If yes, please provide details):

Have you previously been in psychotherapy?

When and for what are the issues?

Was the counseling helpful? (Why or why not)

## RELATIONSHIPS

Do you live with others? What is their relationship to you?

Present Spouse/Partner(s) (first name(s), occupation(s), how would you describe your relationship satisfaction?)

Are there any other current relationships that are a significant focus in your life right now? Please describe:

## OTHER

What are your main worries or fears?

What do you consider your main strengths?

What are your primary challenges right now?

What are your most important hopes or dreams?

Please add any additional information that may be helpful to our work together.

# CLIENT'S RIGHTS

**Counseling Relationship:** The client and clinician usually will meet weekly for approximately 60-minute session. The relationship is a professional relationship rather than a social one. Clinicians will not discriminate on the basis of race, gender, religion, national origin, disability, or sexual orientation. If significant differences, such as in culture or belief system exist, the clinician and client will work to understand those differences.

Some clients achieve their goals in only a few counseling sessions, whereas others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. If you choose to end the counseling relationship, we ask that you participate in a termination session. We also have the right to refuse or to discuss modification of any counseling techniques or suggestions that you believe might be harmful. We render counseling services in a professional manner consistent with accepted ethical standards. If at any time for any reason you are dissatisfied with the clinician's services, please inform the clinician so we can work to resolve your concerns.

**Privacy Rights under HIPAA:** You have the right to review your client file in the presence of your clinician. You may ask for a copy of your file, and will be charge a per page copy fee rate of 10 cents per page. You may ask for corrections or clarifications of the content in the file and that will be recorded in the notes. You may ask to review Sanders & Associates HIPAA procedures.

**Appointments and Cancellation:** Appointments will be scheduled at a time mutually acceptable to both the patient and clinician. It is greatly appreciated that you call ASAP to cancel an appointment. If you miss three consecutive counseling sessions without notifying your clinician, services will be terminated. Also if you fail to cancel your appointment within 24 hours of your scheduled appointment you will be charged a $50 fee. Please refer to your clinician with questions.

**Crises:** If you are unable to reach your clinician and an immediate need or crisis arises, please contact 911 or go to the nearest emergency room. The National Suicide Hotline number 1(800) 784-2433 or 1(800) 273-8255. The hearing-impaired hotline number is 1(800) 799-4889.

**Conditions of Ongoing Counseling:** If you have been in counseling or psychotherapy during the past seven years, you may sign a release so Sanders & Associates may communicate with and/or receive copies of records from the professional(s) from whom you received mental health services, if deemed it is important to do so. By signing this form, you are agreeing to disclose all previous mental health treatment and to reimburse Sanders & Associates for any expenses charged by your previous mental health professional(s) for supplying copies of your records. While you are in counseling, you agree not to maintain or establish a professional relationship with another mental health professional unless you first discuss it with this clinician and sign a release that enables this clinician to communicate with the other mental health professional(s). If you decide to maintain or establish a professional relationship with another mental health professional and treatment services are duplicated, this clinician may consider this your decision to change clinicians, and reserve the right to terminate your counseling.

**Referrals:** This clinician recognizes that not all conditions presented by clients are appropriate for expertise. For this reason, you and/or I may believe that a referral is needed. In that case, some alternatives may be provided including programs and/or people who may be available to assist you. A verbal exploration of alternative to counseling will also be made available upon request. You will be responsible for contacting and evaluating those referrals and/or alternatives.

_____

Client's Signature or Parent/Guardian Date

## CONFIDENTIALITY

Please be advised that Sanders & Associates clinicians are mandated reporters in Illinois. They are also required to make a report if a patient is a lethal danger to himself or herself or others. Danger to self and/or others (i.e. suicide or homicide) may necessitate the breaking of confidentiality. In addition, by law suspected child abuse and/or neglect and elder abuse and/or neglect communicated by clients must be reported to appropriate.

To provide effective assessment and treatment, each clinician will ask many personal questions. Excluding the circumstances listed above, all personal information is kept strictly confidential. No information about you or your case will be released to anyone without your written authorization and consent.

_____

Client's Signature or Parent/Guardian Date

## CONSENT FOR PSYCHOLOGICAL TESTING

In general, a comprehensive psychological assessment will include interviews with you, your child, and/or other family members, a review of records you provide, and cognitive, academic, personality, and/or projective testing. You will receive a comprehensive written report within a few weeks after the conclusion of the assessment. A one to two hour feedback session will be scheduled to review results and recommendations.

I consent for psychological testing for my child or myself. I understand that this process may include me, my spouse, my children, other family members, and/or other professionals. Information will be obtained from other sources when necessary only with my written consent. I understand that I have the right to withdraw from assessment at any time.

Signature of Client or Parent Date

## FEES FOR TESTING

The rate for psychological testing is $320 per hour. Billed hours include time spent conducting interviews and administering tests, reviewing records, scoring and interpreting tests, writing reports, and reporting meeting. The number of hours will vary depending on how extensive your assessment is. Total costs may range anywhere from $1,000 to $5,000.

Your insurance plan will be billed and you will be responsible for any remaining balance your insurance company does not cover, which may include deductibles, co-payments, and co-insurance (this depends on your individual plan). Your benefits will be verified prior to testing, though most insurance companies do not guarantee payment until claims are actually submitted. While our office will verify your benefits, please also note that it is your responsibility to understand your insurance benefits and to what extent services may or may be covered by your plan. You may want to contact your insurance company directly to inquire about coverage.

I authorize the release of any medical or other personal information necessary to process my insurance claim. I also authorize payment of medical benefits to the supplier of services provided to child, family, or myself.

Signature of Client or Parent Date

# CREDIT CARDS

Sanders & Associates requires a credit card on file for all patients. I understand that I am responsible for timely payment of all amounts due on my account with Sanders & Associates. I understand that if I fail to submit a timely payment, my credit card on file will be charged with the payment. I understand that I can speak with my clinician directly to set up a payment plan should that need arise.

Card Holder's Name: _____

Credit Card Number: _____
Visa or MasterCard (circle one)

Expiration Date: ____/____ Security Code: _____ Billing Zip Code: _____

_____
Signature Date

Sanders & Associates is authorized to charge my credit card for my co-payment or full fee at the time services are rendered. If known, amount charged will be $_____ per session.

Client's Signature _____ Date _____