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.

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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

FEES FOR COUNSELING

Fees vary based on type of service and method of payment. We accept most health insurance plans and will discuss out-of-pocket costs with you after your benefits are verified. Sanders & Associates does offer services on a sliding scale basis for patients who require assistance. Please contact a clinician directly to discuss financial arrangements.

Appointments will be scheduled at a time mutually acceptable to both the patient and clinician. If you fail to cancel your appointment within 24 hours of your scheduled appointment, Sanders & Associates reserves the right to charge you a $50 fee. So 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.

Bills that are 60 days past due will be assessed a 1.5% interest fee, and will be sent to collections. You are responsible for all fees assessed by the collection agency.

_____ _____

Client's Signature or Parent/Guardian Date

CREDIT CARDS

I understand that I am responsible for timely payment of all amounts due on my account with Sanders & Associates. I understand that I can speak with my clinician directly to set up a payment plan should the need arise.

Card Holder's Name: _____

Credit Card Number: _____

Visa or MasterCard (circle one)

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

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

_____ _____

Client's Signature or Parent/Guardian Date