Welcome to D. G. Counseling Inc. Please read the following information about our professional series and business polices. Your signature is an acknowledgement of your agreement to abide by these policies.

• Psychological Services

Counseling is a powerful treatment. There are some risks as well as benefits. As with any treatment decision, you should be aware of the risks and benefits of counseling. For example, in counseling you may experience uncomfortable levels of feelings and recall unpleasant memories. In counseling, major life decisions are sometimes made. Changes in relationships, employment or life style may result from participation in counseling. Clients may call into question many of their beliefs and values. Your counselor will be available to discuss any of your assumptions, problems, or possible negative side effects that you may experience in your work together.

The benefits of counseling are many and have been well researched by scientists. People suffering from depression may find their mood lifting. Feelings of fear, anger or anxiety may be relieved. Relationships or coping skills may greatly improve. Personal goals may become clarified. There are no guarantees about the outcome of counseling. As professional licensed counselors we do not accept clients that we do not think that we can help. However, we enter into the counseling relationship with you with optimism.

• Appointments

Appointments are generally **50 minutes.** Except for illness or emergencies, a **24 hour notice** is required for cancelled appointments. If the appointment is not kept or cancelled without 24 hour notice; you will be charged **50%** of the fee. This is not coverable by insurance.

• Fees for Service

Regular sessions of 50 minutes are $250.00, although this may vary. Payment is requested at time of service. Payment may be made by cash, check, or credit card.

• Insurance Reimbursement

Your health insurance policy may provide some coverage for mental health treatment. Remember that we have no role in determining your insurance plan. Please take proper steps to confirm your benefits and deductibles with your insurer.

• Contacting your Counselor

In the event that your counselor or their alternate is not available, please contact your family physician or go to the nearest emergency room.

• Confidentiality

We will treat all your information with great care. We do not divulge anything without your permission in writing. It is your legal right that your information is kept confidential. The only way that we can release information about you is if you sign a **Release of Information Form**. There are a few legal exceptions to your confidentiality.

- If your counselor believes that you are at risk of harming yourself or someone else
- If your counselor believes that a child, elderly person or disabled person is being abused
- If a judge subpoenas records or counselor testimony
- If you report sexual exploitation by another mental health professional

These situations are very rare but it is important that you are aware of these exceptions to confidentiality. Should such a situation occur, your counselor will make every effort to discuss it with you before taking action.

In the case of relationship or family counseling, no information will be released without the signed consent of all adults involved in the counseling. No information about minors will be released without parental/guardian consent.

There are two situations where your counselor may discuss your case with another counselor. The first situation is if your counselor is going to be away for an extended period of time. Another counselor will be available should you need care while your counselor is away. The counselor providing coverage will be told basic information about your case. This counselor is also an employee of D.G. Counseling Inc. The second situation is clinical supervision or consultation with another counselor about cases. **NO** identifying information is shared with the supervisor. Clinical supervision allows us to provide high quality counseling. In both of these cases, the other counselors are required to keep client confidentiality just as your counselor is.

Generally your health insurance company will receive only the dates of your appointments, type of service provided, cost and your diagnosis. This information will become a part of your permanent medical record. We **CANNOT** insure confidentiality of information released to your insurance company. If you have any concerns about the release of information to your insurance company, please speak your concerns.

I acknowledge that I received, read (or have had read to me) and understand the **Consent and Contract for Counseling** form. I further acknowledge that I have had the opportunity to ask questions about this contract with my counselor(s). I acknowledge that I am willingly entering into counseling. I understand that developing a treatment plan with this counselor and regularly reviewing our progress in meeting the treatment goals are in my best interest.

I **agree to take an active role in the counseling process.** I understand that no specific promises have been made to me by my counselor about the results of counseling, the effectiveness of the procedures used by any counselor, or the number of sessions necessary for counseling to be effective. I understand that 1 have the right to speak to my counselor anytime about my progress in counseling. I am aware that I may stop counseling at any time. The only thing that I will be responsible for is paying for the services that I received.
I understand that I may lose other services or have other problems if I stop counseling prematurely.

I agree that I will discuss any concerns about my counseling with my counselor before I end counseling. **I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment or 50% of the fee will be charged to me.** I agree that my insurance company or other third party payer may receive information about the type, date and cost of services, as well as my diagnosis**.** I understand that I am responsible for the payment of fees**.** I understand that my counselor may cease treatment if payment for services is not received.

I understand and agree to the terms and conditions stated on this form.

Client's Signature (or Parent/Guardian's Signature)_____Client's Printed Name_____

I, the counselor, have discussed the issues above with the client and/or parents/guardians. I believe that this person fully understands this contract and is competent and willing to enter into counseling.

Counselor's Signature _____Date_____

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The Strength is in You

Clients Name: _____
First Middle Last

Clients Date of Birth: _____ _____M_____F
Month/Day/Year

Address: _____

_____
City State Zip

Phone Number _____ Ok to leave message _____Y _____N

Email: _____ Referred By: _____

Would you like to receive our exclusive newsletter filled with upcoming events, important info, and monthly tips from our knowledgeable clinicians? ☐ YES ☐ NO

Names and Ages of Everyone Living in the Home:

_____

_____

Insurance Information

Name of Primary Insured_____

Primary Insured Date of Birth_____

Primary Insured Address (if different) _____

Emergency Contact Information

Name _____Phone_____

Signature _____Date_____

Clinician's Signature_____Date_____

Clinician's Printed Initials_____

Privacy Policy (HIPAA)

1. You have a right to know D. G. Counseling, Inc.'s guidelines and procedures regarding your health information and in most instances, to consent or to refuse consent to disclose such information to others. Neither your spouse nor a parent (if a minor) is automatically entitled to receive health information about you. By law, your protected health information may be provided without your consent in some criminal investigations or in certain public health and emergency circumstances.
2. Your protected health information consists of that which we collect in the course of your medical care here and such information as you provide or authorize us to get from others. Such information also may be used for internal quality assurance studies, but study results will not be disclosed to outside agencies so as to identify you or your medical conditions.
3. Your medical record is accessible only to members of D. G. Counseling, Inc. staff serving you. Safeguards regarding incidental use and disclosure of protected information within D. G. Counseling, Inc. have been established which still permit the staff, as part of the supervisory process, to freely explore and discuss the best treatment options with and for you.
4. Your counseling record, created by the professional staff of D. G. Counseling, Inc. is not part of any other medical record.

Your physician needs your permission to see your counseling record, as does your counselor to see your medical record.

Disclosure of Protected Health Information

1. You must specifically authorize D. G. Counseling, Inc. to use or disclose protected information in most non-routine circumstances. D. G. Counseling, Inc. does not sell or otherwise provide protected health information to a business that may want to market its products or services to you.
2. With your written permission, a copy of part or all of a medical record may be sent to other physicians, hospitals, at no charge.

There is a charge for each copy sent to attorneys, investigating agencies, or others you designate.

Your Rights

1. You may request a copy of your record for your personal use. There is a charge for such copies. You may request corrections of your record subject to preserving the integrity of the documentation of the treatment process.

Normally, a review of your medical record should be done in consultation with a health care professional.

2. If you believe your privacy protections have been violated, you may file a formal complaint with D. G. Counseling, Inc. You may also have the right to pursue formal legal actions in state or federal court.
3. This written notice of D. G. Counseling, Inc. privacy practices and your privacy rights is provided as a matter of law. Please acknowledge receipt of this privacy notice by signing on the attached page in the space indicated. A copy of this form will be placed in your permanent medical record. We reserve the right to change our practices and to make the new provisions effective for all individually identifiable health information we maintain. Should we change our information practices, we will mail a revised notice to the address you have supplied us.

Office Copy

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

D. G. Counseling, Inc. Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____

Signature of Client or Client's Representative Date

Print Name

If signing as a Client Representative (such as for a minor child):

_____ _____

Client 's Name Relationship to Client

I, _____, do hereby give my consent to receive electronic communication from my counselor at DG Counseling, Inc. to my email address listed below or via text to the mobile phone number listed below. This consent will remain in effect unless and until rescinded in writing by myself and acknowledged in writing by DG Counseling, Inc. A copy of this consent shall be furnished to the client at the time of signing, if requested.

Email address: _____

Mobile phone number for texts: _____

Client Signature: _____

Parent/Guardian Signature: _____

Client Printed Name: _____ Date: _____

Counselor Signature: _____ Date: _____

Credit Card Authorization Form

I authorize DG Counseling, Inc. to keep my signature and card information on file in order to charge therapy session fees (individual, group, workshops, couples, family or other), and any fees related to therapy related materials (workbooks, DVDs, CDs, other materials, and/or fees), or for any appointments with her 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 agree that the card listed below may be charged by DG Counseling, Inc. in order to settle any outstanding balances accrued by the above listed client upon termination of therapy services including any materials (i.e. books, CDs, DVDs, etc.) that I have not returned within two weeks of completion of my therapy service and therapy fees that are not covered by insurance. I understand that if a chargeback fee is incurred or a retrieval fee of is incurred, I am responsible for these fees.

_____ (Initial here)

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 DG Counseling, Inc. 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 DG Counseling, Inc. and those attempts have failed. _____ (Initial here)

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_____

Billing Address:_____ Zip Code: _____

Card Type (circle one): Visa MasterCard Discover

Card Number: _____-_____-_____-_____

CVC Number: _____

Exp. Date: _____

I understand that my therapy sessions will be charged $100 unless cancelled 24 hours in advance.

Cardholder Signature: _____ Date:_____

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Medication Questionnaire

Please include all drugs you take, including 'over the counter" medications like aspirin, Tylenol, cough syrup, vitamins, homeopathic and herbal products, as well as prescription drugs, regardless of whether they are ordered by a provider or what kind of provider ordered them. **Please write "none" and initial, if you do not take anything.**

Drug Name								
Date Started (Date ended for recent changes)								
Doctor								
What are you taking this for?								
Dose (each time)								
What time(s) of day?								
New Problems or complaints since you began this medication. When did they start?								
Is this medication working?								

Authorization for Disclosure of Mental Health Treatment Information

I, _____ (Name of Patient/Client), whose date of birth is _____, authorize D.G. Counseling, Inc. to disclose to and/or obtain information from:

Name: _____

Address: _____

City, State, Zip Code_____

Phone Number: _____

I understand I have the right to refuse to sign this form and I have a right to revoke this authorization, in writing, at any time, by sending written notification to D.G. Counseling, Inc. 1001 Maple Ave., Downers Gove, IL 60515. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

I may request a copy of this authorization for my records.

This release will expire one year from the date signed, unless otherwise specified.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

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

_____

Signature of Staff Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act, HIPPA, and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient who is a minor, specifically authorizes such disclosure. A separate release is required for psychotherapy notes.