Child Link, Inc.

Individual, Couple, and Family Therapy
955 W. Cermak Rd. Suite 2| Chicago, Illinois 60608
T: 312-377-4735 **E:** Counseling@Childlnk.org

Date:_____

IDENTIFYING CLIENT INFORMATION

Client Name: _____

Birth Date: _____

Phone Number: _____

Cell: _____

Address: _____

Preferred Gender Pronouns: _____

Previous Diagnoses: _____

Marital Status: _____

Employed: Yes No Student: Yes No Employer/School:_____

CLIENT INSURANCE INFORMATION

Insurance Company: _____

Group Number: _____

Insurance Identification Number: _____

Name of Member: _____ **Relationship to Client:** _____

Member's Birth Date: _____ **Member's S. S. #** _____

Member's Employer: _____

Member's Address and Phone Number, if different from the client's:

_____

Phone Number for Benefits:_____

Sessions:_____ **Authorization #** _____

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CONSENT FOR TREATMENT

Your **Child Link, Inc.** service provider is committed to providing quality services to promote physical, emotional, and social health in each client served. Therapy services that are deemed appropriate and necessary are provided to encourage independence and well-being. Treatment varies for each person and will be individualized depending on your needs. The practice of mental health counseling is not an exact science and your Child Link, Inc. service provider should not make any guarantees regarding treatment outcomes.

( ) Initial Here

My Child Link Inc., service provider has provided me with a copy of the Notice of Privacy Practices for Child Link, Inc. and I understand the uses and disclosures are implemented to protect my psychological and mental information. I know that I have the right to file a complaint if I feel my Child Link, Inc. service provider has violated my privacy rights. I also understand that certain circumstances may require that information concerning my care be released without my consent. These circumstances would include:

1. Individual poses a serious danger to self or others
2. Therapist suspects evidence of child or elder abuse
3. Court issues a subpoena concerning records
4. A valid medical emergency occurs

( ) Initial Here

I authorize my Child Link, Inc. service provider to release or request information necessary to determine/obtain benefits from BCBS, Medicare, Medicaid, or other third-party insurance. I request that payment of BCBS, Medicare, Medicaid, or other third-party insurance be made to Child Link, Inc. If my case requires above normal paperwork or lengthy phone conversations, I understand that insurance will not cover these expenses and I will be responsible for payment of these fees. If for any reason, the assignment is not accepted or fees remain after claims have been paid, I agree to pay the entire amount or balance due.

( ) Initial Here

I have read and understand what is written above and agree to treatment. I understand that I have the right to an explanation of the nature and purpose of the services I receive. I have the right to withdraw this consent at any time by submitting a request in writing to Child Link, Inc.

( )
Initial Here

_____
Printed Name of Client

_____ _____
Signature of client or parent/guardian, if client is a minor Date

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Relationship to Client

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ATTENDANCE / CANCELLATION POLICY

To ensure the continuation of quality services, Child Link, Inc. has implemented an attendance and cancellation policy for all scheduled appointments. Please take a few moments to review the policy listed below and sign, in order to indicate your understanding of the policy:

1. Clients must contact Child Link, Inc. at 312-377-4735 at least 24-hours prior to the scheduled appointment to cancel, in order to avoid a fee.
2. In the event a client misses three appointments without prior notification, the scheduled appointment time may be assigned to another client or services may be discontinued.

Fee for a missed appointment with less than a 24-hour notification: $25.00
Fee for a missed appointment with no notification: $100.00

I, _____, have read and understand the attendance policy.
Print Client's Name

_____ _____
Signature of client or parent/guardian, if client is a minor Date

_____ _____
Signature of Witness Date

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STATEMENT OF FINANCIAL RESPONSIBILITY

Authorization of Release of Information to Third-Party Payers: I have provided Child Link, Inc. with the information requiring eligibility and benefits for _____.
(Client Name)

I understand that this authorization will be used by Child Link, Inc. and _____'s
(Client Name)
insurance company to determine eligibility and benefits under the existing policy. Any information obtained will not be released by the insurance company without authorization. This authorization shall be valid during the pending of the claim unless specifically revoked in writing.

Assignment of Insurance Benefits: I hereby authorize payment of benefits otherwise payable to me to be paid to Child Link, Inc. I authorize insurance companies providing coverage for services to make payment(s) directly to Child Link, Inc.

Guarantee of Payment: I guarantee payment of the bill for services provided. Payments of co-payments and outstanding client balances will be collected at the time of the client's session. I understand that I am financially responsible for Child Link, Inc. charges not covered or paid by the insurance company. I will be responsible for pre-certifying my insurance if needed. I understand that if I do not pre-certify, I will be responsible for the entire bill. I agree to pay any unpaid balances within 30 days. I understand that the fees for service are as follows:

$130 per 45-minute session
$150 per 60-minute session
$200 for initial assessment and clinical interview

Change of Insurance: I agree to notify Child Link, Inc. immediately if any changes occur with my insurance policy. Advanced notice to verify benefits **prior** to your next scheduled visit is required. If Child Link, Inc. is unable to verify your benefits and/or reasonable time is not given to verify your benefits, you will be responsible for the entire visit(s).

Service Rates: I acknowledge that I have received a copy of the fee schedule for services from Child Link, Inc. including fees for no shows or cancellations less than 24 hours before the scheduled appointment.

_____ _____
Signature of client or parent/guardian, if client is a minor Date

_____ _____
Signature of Witness Date

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Client Name:_____Date of Birth:_____

Client Phone Number:_____Client Address: _____

The undersign herby authorizes and requests the release of confidential information between Child Link, Inc. and:

Name of Individual/Institution:_____

City, State, Zip Code: _____

Phone Number (work and or home):_____

For review, examination, and or photocopies. Access to this information is limited as designated below:

Release only those portions of The Medical Record Checked:

Entire Record ( )
Initial Assessment ( )
Discharge Summary Only ( )
Progress in Treatment ( )
Presence in Treatment ( )
Other ( ) Please Specify: _____

Purpose of the Release: _____

I fully understand that my medical record contains confidential physical, mental health, substance abuse, and/or HIV/AIDS information complied in the course of my treatment the medical records and/or information authorized to be disclosed above are privileged and confidential and may be disclosed only on my authorization as required by law. I may revoke this authorization at any time (except to the extent that actions have already been taken in good faith reliance on the authorization) by submitting a written revocation request to Child Link, Inc. This authorization expires 60 days after services have been terminated or until all financial responsibilities have been satisfied. This information is disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). The federal rules prohibit any further disclosure of this information unless further discloser is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any substance abuse client.

Client Signature: _____ Date: _____
(parent / guardian if client is a minor)

Witness Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

Uses and Disclosures for Treatment Payment and Health Care Operations

I may use or disclose your protected health information (PHI) for treatment, payment and health care operations purpose with your written authorizations. To help clarify these terms, here are some definitions.

- **PHI** refers to information in your health record that could identify you.
- **TREATMENT** is when Child Link Inc. provides, coordinates, or manages your health care and other services related to your treatment, for example, consulting with another health care provider.
- **PAYMENT** is when Child Link Inc., obtains reimbursement for your healthcare, for example, when Child Link, Inc. discloses information about your treatment to your insurance company.
- **USE** applies only to activities within Child Link, Inc. providing therapist, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- **DISCLOSURE** applies to activities outside of my practice groups, such as releasing, transferring, or providing access to information about you to other parties.
- **AUTHORIZATION** is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of the treatment or payment when your appropriate authorizations are obtained. I will obtain authorization from you before releasing this information. You may revoke all such authorizations of PHI at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization, or (2) if the authorization was obtained as a condition of obtaining insurance coverage (law provides the insurer the right to contest the claim under the policy).

Uses and Disclosures with Neither Consent or Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse/Adult Abuse/Domestic Abuse:** If your Child Link, Inc. service provider has reason to believe that abuse is taking place, your Child Link, Inc. service provider is mandated by law to report this belief to be the appropriate authorities.
- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the services your Child Link, Inc. service provider provided you and/or the records thereof, such information is privileged under state law, and will not be released without your written authorization or that of your legally appointed representative or a court-order. The privilege does not apply when you are being evaluated for any third-party or where the evaluation is court-ordered. If the aforementioned occurs, your Child Link, Inc. service provider will attempt to notify you in advance.
- **Serious Threat to Health or Safety:** If you communicate an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or use other means to cause serious personal injury or death to others, I am mandated by law to notify the potential victim of such danger and to take steps to prevent that harm from occurring. If your Child Link, Inc. service provider has reason to believe that you present imminent, serious harm or death to yourself,

the Child Link, Inc. may need to disclose information to protect you. In both cases, your Child Link, Inc. service provider will only disclose the necessary amount of information necessary.

- **Workers Compensation:** Your Child Link, Inc. service provider may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Client Rights

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of protected health information. However, the Child Link, Inc. service provider is not required to agree to a restriction you request.
- **Right to Receive Confidential Communication by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at an alternative location. For example, you do not want your family to know you are in treatment and want communication sent to an alternative address.
- **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of PHI in mental health and billing records used to make decisions for a long as the PHI is maintained in the record. The Child Link, Inc. service provider may deny you access under certain circumstances, but in some cases you may have this decision reviewed. The Child Link, Inc. service provider will discuss this decision with you.
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The Child Link, Inc. service provider may deny your request. The Child Link, Inc. service provider will discuss the details of the amendment process with you.

Clinician

Child Link, Inc. is required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices for PHI. Child Link, Inc. reserves the right to change the privacy policies and practices described in this notice. Child Link, Inc. is required to abide by these terms currently in effect and required to notify you of any changes to the these terms. If Child Link, Inc. should revise any policies and procedures, Child Link Inc., will provide the revised version by mail or through direct exchange.

Complaints

If you are concerned that the Child Link, Inc. service provider violated your privacy rights or you disagree with a decision the Child Link, Inc. service provider made about access to your records you may send in a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Effective Date, Restrictions, and Changes to the Privacy Policy

This notice is effective February 25th, 2020