The Barrington Center for Counseling and Psychotherapy
901 Fox Glen Court, Barrington, IL 60010 · 847.304.0780

REGISTRATION & INTAKE

Person to be Seen:

Date: _____ Date of Birth: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ May we leave a message at this number: _____

Alternate Phone: _____ May we leave a message at this number: _____

Email Address: _____

Responsible Party Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Alternate Phone: _____ Work Phone: _____

Insurance Information: *(please have Insurance card available for verification)*

Insured's Name: _____

Relationship to Patient: _____

Employer's Name: _____

Occupation: _____

Insurance Company Name: _____

Insurance ID Number: _____ Group / Plan Number: _____

Insured's Date of Birth: _____ Insurance Company Phone: _____

FOR OFFICE USE ONLY:

Therapist: _____ **DX:** _____ **Session Fee:** _____

Emergency Contact:

Name: _____ Phone: _____

Address: _____ City: _____ State: ____

Relation to Patient: _____

General Information:

The primary reason you have come to The Barrington Center: _____

_____

How were you referred to our practice? _____

People living in the household (names, ages and relation to patient):

_____

_____

Marital/Relationship Status: _____ Occupation: _____

Highest Grade/Level of Education Completed: _____

Medical / Health Information:

Current Primary Doctor: _____ Phone: _____

Office / Hospital Address: _____

Psychiatrist: _____ Phone: _____

Office / Hospital Address: _____

List all significant medical conditions that may be relevant to your current wellbeing and treatment:

_____

_____

_____

Have you ever been hospitalized for emotional / behavioral health reasons? Yes ☐ No ☐
If yes, please list hospital(s) and date(s) (month / year): _____

_____

Current Medications

List all medications taken regularly, dosage, and condition or symptoms for which the medication is taken (include over-the-counter and supplements): _____

_____

_____

Name of prescribing doctor (if different from above): _____

Phone: _____

Would you like your therapist to be in contact with your doctor(s)? Yes ☐ No ☐
(*If Yes, a consent to exchange information will be completed by your therapist*)

Health Habits:

Do you usually eat healthy? Yes ☐ No ☐

Do you regularly engage in physical activity? Yes ☐ No ☐

Do you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐

Do you use substances (including prescriptions not prescribed to you)? Yes ☐ No ☐

Spiritual:

Are you religious / spiritual? Yes ☐ No ☐

If yes, how do you express this? _____

_____

Leisure:

What do you enjoy doing during your free time?

_____

_____

Current Concerns (please check all that apply):

- ☐ Depressed / Low Mood or Mood Swings
- ☐ Lack of Motivation
- ☐ Difficulty Thinking or Making Decisions
- ☐ Worthlessness
- ☐ Thoughts of Death or Suicide
- ☐ Family Relationships
- ☐ Significant Increase / Decrease in Eating or Weight
- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Frequent Headaches, Stomachaches or Illnesses
- ☐ Temper / Anger
- ☐ Problems Related to Divorce or Separation
- ☐ Gender or Sexuality
- ☐ School Attendance / Academics
- ☐ Irritability / Easily Annoyed
- ☐ Decreased Energy or Fatigue
- ☐ Sleep
- ☐ Hopelessness
- ☐ Self- Injury
- ☐ Social Relationships
- ☐ Body Image
- ☐ Chronic Worry or Fears
- ☐ Obsessions / Compulsions
- ☐ Attention / Concentration
- ☐ Grief / Loss
- ☐ Trauma or Significant Stressors
- ☐ Alcohol / Substance Use
- ☐ Workplace
- ☐ Other (please provide a brief explanation): _____

Prior Treatment

Have you received counseling / therapy in the past? Yes ☐ No ☐

If yes, when did you receive counseling / therapy, where, and for what purpose? _____

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THERAPY CONSENT & AGREEMENT

Welcome to The Barrington Center for Counseling and Psychotherapy. This document contains important information about our services, fees and business policies. Please read it carefully. Your therapist can discuss any questions you may have about it.

Professional Fees:

I understand that if I choose to use health insurance, BCCP will contact my insurance provider to inquire about available mental health benefits and will share that information with me as a courtesy and not a guarantee of payment. My signature gives BCCP permission to release necessary information to my insurance provider related to treatment on my, or my dependent's, behalf in order to obtain reimbursement for services rendered. The remaining balance not covered by insurance (including deductible, co-payment, co-insurance, and services not covered) is my responsibility or the responsible party for dependents. If I do not have insurance, or choose to do self-pay, I understand that I will be responsible for the total fee at the time of service.

I understand that it is my responsibility to promptly notify BCCP if my insurance provider changes. I agree to contact my insurance provider to expedite payment to BCCP for services not reimbursed within 30 days. I also agree to promptly remit insurance payments to BCCP in the event that I receive payment directly from my insurance provider.

Clinical services will be charged based upon the following Fee Schedule. Session length is determined by the therapist's discretion and the guidelines set by your insurance provider, if applicable.

Psychologists:

Initial Consultation / Diagnostic Interview	CPT code 90791	$200
Individual Psychotherapy 53+ minutes	CPT code 90837	$175
Individual Psychotherapy 38-52 minutes	CPT code 90834	$150
Individual Psychotherapy 16-37 minutes	CPT code 90832	$ 90
Family Therapy 26+ minutes	CPT code 90846/90847	$175
Psychological Testing 55-60 minutes	various CPT codes	$200

Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC):

Initial Consultation / Diagnostic Interview	CPT code 90791	$175
Individual Psychotherapy 53+ minutes	CPT code 90837	$155
Individual Psychotherapy 38-52 minutes	CPT code 90834	$135
Individual Psychotherapy 16-37 minutes	CPT code 90832	$ 80
Family Therapy 26+ minutes	CPT code 90846/90847	$155

Fees Not Covered by Insurance:

Requests for the therapist's time beyond sessions will be at the therapist's discretion and cannot be billed to insurance. Therefore, the following fee(s) to provide additional services becomes my responsibility:

- Phone Consultations over 10 minutes will be charged $25 for each 15 minutes (unless a teletherapy session is scheduled, and then we will bill insurance accordingly).
- Court Related Services: $500 per hour paid in advance (including preparation and travel)
- Letters, Reports, Treatment Summaries, and Documentation: $75 per half hour (includes preparation)
- School Staffing or requests for On-Site Services/Attendance: $125 per hour (including preparation and travel)

Appointments:

I agree to give 24-hours prior notice if unable to keep an appointment. Missed appointments, or appointments cancelled without 24-hours prior notice, will be charged **$50** for the first occurrence and **$100** thereafter for each missed appointment. Insurance cannot be billed for these appointments, and without sufficient notice the time is unavailable to others. Therefore, this fee becomes my responsibility. This fee also applies to late cancelled/no show appointments scheduled for my dependents.

Credit Card on File:

BCCP requires a credit/debit card be kept on file to assist in the timely collection of outstanding balances. I understand my credit/debit card will be automatically charged at the end of each month for any balance remaining on my account, and I am responsible for maintaining a valid card on file throughout my time in services. If BCCP is unable to collect payment, or a balance remains after 30 days, I understand my account may be referred to an outside firm for collection, and I will be responsible for all collection costs including any reasonable attorney fees.

Prior to starting services, your therapist or The Barrington Center office will collect your credit card information to be retained in our HIPAA compliant/secure electronic records system. For security reasons, we advise against sending this information by email, text, etc. Thank you.

My signature below confirms that I have read and agree to the information stated within The Therapy Consent and Agreement.

Patient Signature (including patients 12 -17 yrs. old) Date:

Therapist/Witness Signature: Date:

Parent/Guardian Signature: Date:

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Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, this notice describes how health information about you may be used and disclosed and how you can access this information.

Understanding Your Health Information and Health Record

Each time you visit your psychotherapist at the Barrington Center for Counseling and Psychotherapy (throughout this document referred to as the "Center"); we document information about you and your visit. Typically, this record is referred to as your Behavioral Health Record and contains your name, symptoms, history, diagnoses, treatment given and a plan for future care or treatment. This record is used to document and plan your care and treatment and be a source of your health information.

Use and Disclosure of Your Health Information

The Center will use and disclose your health information contained within the behavioral health record to give you treatment, obtain payment for your treatment, and operate our psychotherapy business.

Some examples of how your health information may be used or disclosed include the following:

1. Your therapist will collect and document information about you in your record. We may disclose information to a physician or other health care provider who will be assisting or consulting regarding your care. This information will be used to evaluate or choose the treatment we believe is best for you. This treatment will always be coordinated with you. We will document in your record the suggestions and observations made of you.
2. We will send a bill that includes some of your health information to you, to the person responsible for the bill, and your third party payer (such as your Health Insurance Company or Medicare). In some instances, we may need to send part of your record to your third party payer. The type of health information we might send includes your name, other identifying information, diagnosis, treatment, and possibly a summary of your progress.
3. We will use and/or disclose your health information to those persons or companies for which you give us written authorization or permission to do so. If you authorize us to use or disclose your information, you must complete our Release of Health Information Form. You may revoke your authorization in writing at any time to the extent that we may have already used or disclosed your health information as previously authorized.

The Center may without your written permission release your health information for the purposes described below.

- **Business Associates:**
  We provide some services through other persons or companies that need access to your name or

health information to carry out these services. The law refers to these persons or companies as Business Associates. Our 24 hour answering service would be an example of such an associate. Billing or collection service would be an additional example.

- **Law Enforcement Officials:**
  We may disclose your health information to the police, other law enforcement officials, and to the courts or administrative proceedings as allowed or required by law, or required by a court order or other legal process. We also must report known, or suspected, incidents of child abuse or neglect or elder abuse or neglect.
- **Notification and Other Communications with your Relatives, Close Friends, or Caregivers:**
  You or your legal representative must tell your therapist which of your relatives or other persons may receive information about you. After learning who these persons are, we may, in our best judgment, use and disclose your health information, to notify these person(s) of what they need to know to care for you. In an emergency or other situation where you are not able to identify your chosen person(s) to receive communications about you, we may exercise our professional judgment to determine whether such a disclosure is in your best interest, who is the appropriate person(s) and what health information is relevant to their involvement with your healthcare or safety.

Patient's Rights

Your behavioral Health Record is the physical property of the Center; however the information within the record belongs to you. Federal and Illinois Laws provide you with the following rights regarding your health information that is contained in the record that the Center keeps about you.

- Right to obtain a copy of this Notice of Privacy Practices
- Right to request certain restrictions on the uses and disclosures of your health information
- Right to inspect or receive a copy of your health record
- Right to request an amendment to your health record if you believe it contains an error
- Right to obtain a list of all the people and companies which the Center has released your health information (an "accounting" of disclosures)
- Right to request that we communicate with you about your health care at a confidential phone number or address
- Right to revoke your written consent / authorization to use or disclose your health information except when the use or disclosure has already happened.

Federal and Illinois Laws also provide you with the right to be informed about and give your written authorization before any health information, is disclosed, unless such discloser is allowed or required by law.

The Center's Responsibilities

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you

- Do what is required by this Notice or a Notice that is in effect at the time The Center uses or discloses your health information
- Notify you if we are unable to agree to your requested restriction on disclosure if your health information
- Agree to reasonable requests to communicate your health information by an alternative method or at an alternative location

Complaints

If you would like to report a Privacy Problem, want further information, or believe your privacy rights have been violated, you may file a report with Dr. Cheryl Borst at the Center at (847)304-0770 ext 1, or you may send a written complaint to the Secretary of the US Department of Health and Human Services, or to the office of Civil Rights (OCR). We will not retaliate against you if you file a complaint with us or with the Directors of OCR or HHS.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice is to into effect on April 13, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all records that we maintain. We will provide you copies of any revised notice.

Acknowledgement: I/we have received a copy of the "Notice of Privacy Practices."

Patient (including patient's 12-17 yrs. old)	Date
Witness/Therapist	Date
Parent/Guardian	Date

The Barrington Center for Counseling and Psychotherapy

We appreciate the confidence you have placed in us by making this initial appointment. Please read this contract carefully and discuss any questions or concerns you might have with your counselor.

I agree to engage BCCP and its practioners to render consulting and psychological services to:

_____

(Patient's name)

I understand that if I choose to use insurance, BCCP will contact my insurance company to inquire about available mental health benefits, and will share that information with me as a courtesy only, and not as a guarantee of payment.

I understand that if my insurance is a "managed care" type of benefit, my BCCP doctor/counselor is required to submit a "treatment plan" to the managed care contractor. This usually includes diagnosis, description of the problem, personal background information, treatment goals and therapy methods. My signature gives BCCP the permission to submit this information on behalf of myself (or my minor) if I choose to utilize my insurance benefit.

I understand that payment is due at the time of service. If benefits have been verified, I am responsible for the co-pay portion at each session. Otherwise, I will pay in full.

If my insurance carrier changes, I agree to contact BCCP with that information and readjust my co-pay accordingly if necessary.

I agree to contact my insurance company to expedite payment to BCCP if payments are not made promptly (over 30 days). I also agree that in the event that I receive insurance payments directly from my carrier, I will promptly remit that amount of payment to BCCP.

I understand and agree to give 24 hours prior notice if unable to keep an appointment. Since insurance companies cannot be billed for missed appointments, I understand that it is my sole fiscal responsibility.

I understand that my doctor or counselor may be required by law to release information without my approval to specific professional and others if:

- There is a clear and serious danger of harm to anyone
- A judge required specific information in a court case
- It is suspect that a criminal offense of child abuse has occurred.

I understand that this consent can be revoked at any time by submitting a written notice to BCCP.

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.

_____

Patient (including patient's 12-17 yrs. old) Date

_____

Witness/Therapist Date

_____

Parent/Guardian Date