The Couple's Place/Adam Krieger, LCSW ----- Client Information Form

Today Date ___/___/___ **New Client** ☐ **Returning Client** ☐ **Group** ☐ ________________________

IDENTIFIED CLIENT (If a specific child is the identified client, provide their information.)

______________________________ ______________________________

Last Name First Name

_____ /_____ /_____ Age ___ Gender: Male__ Female __ ______________________________

Date of Birth Employment /School

______________________________ ____ /____ /____ ______________________________

Name of partner/spouse Date of Birth Email (if attending as a couple)

Marital status of adult/parents: __Divorce__ Living cooperatively__ Married__ Never Married__ Separated _Single

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RESIDENCE (where does the identified client live)

______________________________ ____________________ IL ______________

Address City Zip

Home Phone______________________________ Can we call? ☐ yes ☐ no Leave message? ☐ yes ☐ no

Cell Phone______________________________ Can we call? ☐ yes ☐ no Leave message? ☐ yes ☐ no

Email (write clearly) ____

May we email if needed? ☐ yes ☐ no *Under no circumstance will email information be shared or sold*

Emergency Contact

______________________________ ____________________ ____________________

Name Relationship Home/Cell Phone

Primary Insurance

______________________________ ____________________ ___/____/___

Person Responsible for the account Relationship DOB

______________________________ ____________________

Address (if different from client) Phone Number

_______-_________-_____________ ______________________________ ____________________

SS# for Policy Holder Employer Job Title

______________________________ ____________________

Employer Address City Zip Employer Phone

______________________________ ____________________ ____________________

Insurance Company Group Number Policy Number

______________________________ ____________________ ____________________

Insurance Phone Number Certification/Authorization # # of Sessions Authorized

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Who Referred You

The Couple's Place/Adam Krieger, LCSW

Financial Agreement

Insurance:

It is up to you to check your insurance plan and the limits of your coverage. For initial sessions, you will be required to obtain approval/authorization/certification. If you do not obtain this prior to the first session, you will be responsible for full payment. When in-network, Adam Krieger, MA, LCSW will get approval for subsequent sessions. Adam Krieger, MA, LCSW is willing to assist you by filing insurance claims (for in-network). If your insurance company does not pay your bill in full within 30 days, we ask you to contact your insurance company to help speed up payment. Your insurance policy is between you and your insurance company. We may not be party to that relationship. Our primary relationship is with you, not your insurance company. All charges are your responsibility whether your insurance company pays or not. You will also need to notify us of any changes in your insurance plan. If you do not notify us, and your new policy does not cover services, you will be billed for the full payment.

This practice is out-of-network for some insurance companies. Most, if not all, insurance companies directly reimburse the client for services received. However, the rate and amount is arbitrarily determined by one's own personal insurance policy. A receipt for services will include: 1) date of services; 2) your payment amount; 3) DSM-IV diagnostic code; insurance code (CPT) for type of session. The client is responsible to submit receipts, along with a reimbursement form if needed, directly to their insurance provide. Adam Krieger, MA, LCSW, cannot guarantee insurance reimbursement, as this is solely determined by one's own insurance policy and provider contract. The Client agrees that payment is his/her sole responsibility of the Client.

<u>For both ethical and clinical reasons, Adam Krieger/The Couple's Place does not directly submit to insurance for Couples Counseling</u>. Most plans do not accept Couples Counseling and require the therapist to diagnose an individual.

Payment Policy:

You are expected to pay for all fees/co-payments at the end of each appointment, unless special arrangements have been made. Payment for services is due at the time services are rendered. Adam Krieger, MA, LCSW accepts all major credit cards, cash or checks. There is a $25.00 fee for returned checks. We understand that things do happen and financial problems may affect timely payment of your bill. We will do everything we can to help you. All we ask is that you contact us as soon as possible to make arrangements.

Divorce Situation:

Adam Krieger, MA, LCSW looks to the adult who has brought the child in for the appointment to be responsible for payment of services which are rendered to the child. We also expect the parents to be able to work out payment arrangements with each other and not involve our office in any disputes which may arise.

Cancellation policy:

Unless appointments are cancelled at least 24 hours in advance of their scheduled time, there will be a $50.00 fee charged. Insurance will not reimburse for missed sessions.

Collection Costs and Procedures:

If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including, but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy, you acknowledge that Adam Krieger, MA, LCSW reserves the right to release any patient information and any medical records to our collection agency deemed necessary to assist their staff and attorneys in the collection of this debt.

Assignment and release:
I hereby authorize payment to be made directly to Adam Krieger, MA, LCSW and fully understand that I am the responsible party for all charges incurred by me or my dependents at Adam Krieger, MA, LCSW. I also authorize the release of any and all information required to collect or process my claims. If legal action becomes necessary, I agree to pay all reasonable fees.

By signing below, you do affirm that you read and understood our Financial Policy and that you agree to its contents.

Name of patient: ________________________________ Date: _______________

Signature of patient or responsible party: ____

INFORMED CONSENT
The Couple's Place/ADAM KRIEGER, LCSW

We would like you to fully understand several important aspects of how we work. Please read this and ask for clarification if necessary before you sign.

YOUR CONFIDENTIALITY

Confidentiality is our highest priority. All members of your therapy team are required by legal and ethical standards to maintain strict professional confidentiality.

Except in very unusual situations you can be certain that what you say in your sessions will be known only to yourself and the therapist(s) participating in the family therapy program. The exceptions include the following:

1. Disclosure of intent to harm yourself or others.
2. Disclosure of knowledge of felony crimes that could result in death or serious injury.
3. Information about child/elder abuse or neglect.
4. Finally, we will attempt to maintain your confidentiality according to the ethical standards of our profession. However, information that you wish to keep from a family member may not be considered privileged information by a court of law.

COUNSELING GUIDELINES

We have chosen to discuss the guidelines of counseling out of an ethical commitment. We hope this will help you make an informed choice to participate with us in addressing your concerns. This commitment will carry through your counseling. At any time you may ask us to explain why we're gathering information or prescribing a new approach. We will be glad to explain the purpose behind our practices.

Moreover, counseling by itself may not resolve your problem or concern. Thus, we do our best to assess the program on a week-to-week basis. Chronic non-improvement is treated as a reason for possible referral.

NO SECRET POLICY FOR COUPLES

When a couple enters into counseling, it is considered to be one unit. This means that my allegiance is to the couple "unit," and not to either partner as individuals. This means that we will not hold secrets for either partner. This policy is intended to allow the therapist to continue to treat the couple by preventing, to the extent possible, a conflict of interest to arise where an individual's interests may not be consistent with the interests of the unit being treated. On occasion during the counseling process, individual partners may be seen for an individual counseling session. In this case, the individual session is still considered as part of the couple's counseling relationship. Information disclosed during individual sessions may be relevant or even essential to the proper treatment of the couple. If an individual chooses to share such information with us that has a significant impact on the partner, we will offer the individual every opportunity to disclose the relevant information and will provide guidance in this process. If the individual refuses to disclose this information within the couple's session, we may determine that it is necessary to discontinue the counseling relationship with the couple. If there is information that an individual desires to address within a context of individual confidentiality, we will be happy to provide referrals to therapists who can provide concurrent individual therapy. This policy is intended to maintain the integrity of the couples/marital counseling relationship.

COURT PROCEDING AND SUBPENAS FOR MARITAL CASSES

It is understood that the purpose of marital/couples therapy is for the amelioration of distress within a relationship. Therefore, if both partners request my services as a therapist, they are expected not to use information given to me during the therapy process against the other party in a judicial setting of any kind, be it civil, criminal, or circuit. Likewise, neither party shall for any reason attempt to subpoena my testimony or my records to be presented in a deposition or court hearing of any kind for any reason, such as a divorce case. Release of Records Both partners must provide their consent to release marital/couples counseling records. If one partner does not provide consent, records will not be released. Course of Treatment The continued participation by each person is voluntary. Either participant may suspend or terminate the therapy at her or his individual request.

THERAPY FEES AND SERVICES

Therapy sessions are 55 minutes long and are based on the current rate (see Facts About Services) or based on in-network provider insurance plans. Clients are responsible for any per visit co-payments, and for any applicable deductibles set by their insurance plan. Regardless of insurance plans and benefits, clients are fully responsible for the payment of fees. Payment is expected at each session. I accept cash, credit or personal checks.

This document must be signed by any minor 12 years of age or older. When you have read to this point and have asked for clarification if necessary, please read the following paragraph and sign below:

My signature below indicates that I give my full and informed consent to receive services and policies.

Print Client or Guardian	Date	Signature	Date
Print Client or Guardian	Date	Signature	Date
Client (12 or over)	Date	Signature	Date
Therapist/Witness	Date	Signature	Date

The Couple's Place/Adam Krieger, LCSW

Facts about the services you are about to receive – For Your Records

What is the length of time therapy usually lasts?

The length of time an individual or couple participates in therapy varies. Factors that influence this would include: an individual's motivation, depth of problem, external and internal resources, and response to treatment. Some individuals may respond quickly to therapy and may need only a few sessions. Others may have more complicating factors that would necessitate therapy lasting longer.

How long do sessions last?

Sessions usually last 50-55 minutes. When possible, the first couples session lasts 90 minutes.

How much does it cost?

Most therapy is covered by insurance. You may have a deductible or copayment which varies with each insurance and insurance plan. Check with your insurance company to see what your benefits are.

Standard Fees:

Couples/Family/Individual Therapy*

55 Minute Session *$120.00*

90 Minute Session *$165.00*

Divorce Mediation

60 Minute Session *$140.00*

**A reduced rate may be considered if there is no insurance and you cannot afford the regular rate out of pocket.*

Special Message to Couples about Secrecy

Please know that couple's therapy must be an open and transparent process. As a couple's therapist, my client is the relationship and I cannot hold secrets. This means that clients should be prepared to disclose any issues that are putting their relationship or partner's health in jeopardy, such as an active affair. Secrecy about important issues that directly impact the relationship makes creating intimacy impossible. As a couple's therapist, I will encourage openness and honesty in our communication and therapy. In some cases, when one partner is not prepared to be open and honest in therapy, it may be best to start with individual therapy.

Most important, changing old patterns of communication and problem-solving takes time. Ultimately, couple's therapy does not promise to fix every problem, but to provide the tools to better communicate, feel closer and resolve differences

Who else will know that I am going to therapy?

Your participation in therapy will be kept confidential. What you say to your therapist stays between the two of you. Unless your permission is received in writing, your therapist will not be able to even acknowledge that he or she is meeting with you. This is your right according to Federal and State laws and by the governing body of Social Workers. The only exceptions to this are when there is a threat to yourself, threat to others, child or elderly endangerment, or court subpoenas.

What usually takes place in sessions?

Usually the first session covers a lot of general information your therapist needs to know. The therapist will ask many

questions to get an indication of your areas of concern, how long these have been an issue, family background and history, support systems, and other information that might prove helpful in evaluating your problem. Your therapist will be taking notes during the first session, but subsequent sessions will be more interactive. You may be given handouts and/or assignments to help practice new skills, track important information or integrate into daily life new behaviors.

Who should attend the first session?

It is recommended that all parties involved attend the first session. If you are coming for couples counseling, both partners should attend (this allows everyone to feel like they are starting on equal footing).

Feel free to call 847-652-0453 or email questions to info@thecouplesplace.com.

Client Consent/Waiver For Primary Care Physician Notification of Service Provision
Pursuant to Illinois Law (PL 86-1434) you are hereby notified that it is desirable that you confer with your primary care physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, I am required to notify your primary care physician that you are seeking or receiving mental health services.

Please indicate your desire by checking the appropriate box.

( ) I do not have a primary care physician and don not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** of a primary care physician that I am seeking or receiving mental health services.

( ) I **WAIVE NOTIFICATION** of my primary care physician that I am seeking or receiving mental health services, and I direct you **NOT** to notify him or her.

( ) I **AGREE TO YOUR NOTIFYING** my primary care physician, that I am seeking or receiving mental health services.

My primary care physician is:

Name: ______________________________ Phone #: __________________________________

Address: ____

Please act in accordance with these, my instructions:

Client name: _________________________________ Date: ________________

Client signature: _______________________________

Parent\Guardian signature: _______________________
(required if client is 17 or under)

Witness: ______________________________ Date: ________________

The Couples Place/Adam Krieger

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Patient Name____

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.
You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide healthcare services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Client Name:__________________ Date:______ Signature: _________________
(12 and older)

Guardian Name: __________________ Date: ______ Signature: ______________

The Couple's Place
Adam Krieger, LCSW
649 Barron Blvd, Grayslake, IL 60030 – P 847-652-0453/F 847-261-9972

CONFIDENTIAL STATEMENT OF RELEASE

I hereby authorize The Couples Place/Adam Krieger to release and/or exchange of

information with ________________________________ ________________________
Person/Agent Agency

____
Fax or mailing address

Information to be shared:
___ Client History ___ Educational History ___ Psychological tests/reports

___ Case Management ___ Psychiatric evaluation ___ Initial work-up Psychological test

___ Treatment Progress/Recommendations ___ Evaluation/Assessment

For the purpose of: Facilitation of care

I hold harmless The Couples Place/Adam Krieger, MA, LCSW, authorized for release or exchange. This release expires 60 days after termination of services or at the discretion of the signed party. I have the right to cancel this release at any time, however, cancellation does not affect past action. I understand that I have the right to inspect and copy the information to be disclosed. It is understood that a refusal to authorize the release of the information specified above will prevent to disclosure of such information to the organization identified above, which may result in your not receiving the level of service you need.

Printed Name of Patient:__________________________________ Birth date:____/____/____

Client Signed: ____ Date:____/____/____

Signature of Parent or Guardian:________________________________ Date:____/____/____
(if 17 years of age or under)

Witness:____ Date:____/____/____

Notice to recipient: Under Illinois and Federal Confidentiality provisions, you may not redisclose any of the information provided without specific authorization for such redisclosure. A photocopy of this authorization is as authentic as the original signed statement of release. An original will be retained in the medical records.