Michelle Heyden, MAAT, LCPC
2334 W. Lawrence Ave, Suite 218
Chicago, IL 60625

CLIENT INFORMATION

Client Name:_____ Date of Birth:_____

Billing Address:_____ Age:_____

City: _____ Zip Code:_____ Marital Status: S M W D

Email Address:_____ Ok to Send Correspondence: Yes No

Home Phone:_____ OK to Call?: Yes No

Work /Cell Phone: _____ OK to Call?: Yes No

Employer Name:_____ City:_____

PRIMARY INSURANCE

Insurance Carrier:_____

Phone Number on Back of Card for Mental Health Benefits:_____

Identification Number:_____ Group Number:_____

Is Patient Policy Holder?: Yes No Policy Holder Relation to Patient: Self Spouse Child Other

Policy Holder Name:_____Policy Holder Date of Birth:_____

Secondary Insurance Available: Yes No

Please read the following carefully and sign below:

I give permission to Michelle Heyden, LCPC and her billing staff to send required information to my insurance company(s) or my EAP. I am aware that I am placing my signature of file and that I will be responsible for any unpaid balances such as co-pays, deductibles, and non-covered services. I understand there is a fee if I fail to give at least 36 hour notice for cancellations of my appointments and that my insurance or EAP does not cover the cost of missed sessions.

Signed:_____ **Date:**_____

(please turn over)

Client Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: This is in case of a medical or psychiatric emergency. This emergency contact person should be someone with whom you have frequent contact and would be most aware of any physical, psychiatric, and emotional issues that you have been experiencing. If this contact is not available in an emergency or if you cannot identify a contact person, 911 may be called to ensure personal safety.

Name: _____

Relationship: _____

Phone Number: _____

Primary Care Physician

Name: _____

Hospital/Group Name: _____

Phone Number: _____

Psychiatrist (if applicable)

Name: _____

Hospital/Group Name: _____

Phone Number: _____

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Informed Consent

Welcome
These guidelines have been written to inform you, the client, about the basic terms, conditions and professional practices that promote a successful therapeutic experience. Please read this information carefully and acknowledge your understanding by signing below.

Credentials
Michelle Heyden holds a Master of Arts in Art Therapy degree from University of Illinois at Chicago. Since 2005, Michelle has been a Licensed Clinical Professional Counselor, which is a professional license that initially involved 2 years of supervised clinical work in addition to state and national board exams and requires continued education to renew. The LCPC license allows Michelle to ethically and legally conduct psychotherapy sessions to treat mental health issues and disorders in the state of Illinois.

The Psychotherapy Process
Psychotherapy may include many different methods of treatment; however, most importantly, it requires active effort on your part. Clients normally experience a range of reactions following sessions throughout the therapeutic process. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, and/or frustration. On the other hand, psychotherapy has been shown to lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, not all clients benefit from the psychotherapy process, in the event that this occurs, the therapist and client will make a plan for appropriate resources and referrals. My goal is to create a safe, non-judgmental environment in which you can discuss any concerns that you may have about your treatment.

Appointments
The best results occur when you consistently schedule appointments and maintain regular attendance. To adequately assess your needs and build a solid therapeutic relationship, weekly sessions are strongly recommended for at least the first six weeks. Each session lasts approximately 52 minutes. ***Since insurance does not pay for missed sessions, you will be responsible for paying the cancellation fee of $85 (or the regular session fee amount if self pay) for any appointments which are cancelled or rescheduled with less than 36 hours notice.*** In cases of emergency or special circumstances, where 36 hours notice is not possible, the late cancellation fee may be waived. Although I provide billing services (if I am an in-network provider) to submit claims on the client's behalf, you are responsible for session fees if claim payments are denied by your insurance company. You are also responsible for notifying me at least 2 sessions ahead of time if you change insurance policies and/or your pre-authorized session limit will be reached.

Payment for Services
Payment for professional services is due in full at the time services are provided unless other arrangements have been made. There is a $25 fee for all returned checks. If you choose to pre-pay for sessions, payment for any services not rendered will not be returned if client decides to discontinue treatment.

(please turn over)

Contacting Information
Between appointments, you may leave a message or contact me using the contact information above. I am often not immediately available; however, I will make every effort to return your call/e-mail within 24- 48 hours except on holidays and weekends. Phone calls should be limited to scheduling communications regarding appointments and urgent concerns. E-mails should only be used for scheduling issues. In case of an emergency (if you or another is at immediate risk of harm) you are advised to proceed to the nearest emergency room or dial 911.

Policy on Legal Proceedings
I do NOT assist clients in legal matters at the request of the client. However, if I am subpoenaed by a judge, I am required to comply with legal proceedings. Prior to being deposed or testifying in court on behalf of a client, the client must agree in writing to waive his/her right to confidentiality. By doing so, the client is allowing his/her records to be reviewed and scrutinized by non-clinical persons involved in the legal case. Additionally, it is understood that a therapist's testimony may not always work in favor of the client's case.

Court and legal proceedings are very time consuming and may require preparation by the therapist. Due to this, there are fees allotted to each type of legal involvement which are due PRIOR to the service. If the therapist is required to appear for a deposition, the client is required to pay $600.00 at least 96 hours prior to the deposition. This fee covers three hours of time in a deposition and one hour of travel. If the deposition and travel equate to more than four hours of the therapist's time, the client will be billed at the rate of $150.00 per hour, including any time the therapist needs to review your file and prepare for the deposition.

If the therapist is asked or required to appear in Court, the client will be required to pay $1,200 at least seven days prior to the Court appearance. This fee represents an eight hour day. The client will be billed at the rate of $150.00 per hour for any time over eight hours spent by the therapist for travel, preparation, waiting, or to testify in court.

I, as the client, agree to pay for all services provided up until the time the therapy relationship has ended. I have read and understand all of the terms and conditions stated above regarding therapy. I understand and agree to the terms and conditions of this agreement.

_____	_____	_____
Date	Signature of Client	Printed Name

_____	_____	_____
Date	Signature of 2nd Client, if applicable	Printed Name

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Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. STATEMENT OF LEGAL DUTIES

As your clinician, I am required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with a notice of my legal duties and privacy practices. I am permitted by federal and state privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operation purposes with your written authorization.

Protected Health Information (PHI) is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, assessment results, diagnoses, treatment, and plan for future treatment. In some circumstances, it may include billing documents for those services. Psychotherapy notes provide an even greater degree of protection and can only be released with a separate authorization.

Example of Uses of You Health Information for Treatment Purposes:

- I may disclose your health information to provide, coordinate of manage your treatment including others outside my practice with whom I am consulting or to whom I may be referring you.

Examples of Uses of Your Health Information for Payment Purposes:

- If applicable, I may submit requests for payment to your health insurance company. If the health insurance company (or other business associate helping us obtain payment) requests information from me regarding treatment, diagnosis, and my recommendations for future care, I will provide information to them about you and the care given.
- If applicable, I may contact insurance providers to verify benefit eligibility and coverage, determination of payment status and utilization review activities.

Example of Use of Your Information for Health Care Operations:

- I may use and disclose your health care information in connection with the financial, administrative, legal and quality improvement activities necessary to run the practice and support the continuance of treatment services.

II. ILLINOIS STATEMENT OF YOUR RIGHTS

The health and billing records I maintain are the physical property of me as your clinician. However, the information in these records belongs to you. You have the following rights:

- The right to request a restriction on certain uses and disclosures of you health information by delivering a written request to my office. I am not required to grant the request.
- The rights to access, inspect, and copy your PHI in the files I maintain about you. These must be requested in written form and delivered to my office. You may be charged a fee for copying and postage of PHI.
- The right to obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at my office.
- The right to appeal a denial of access to you protected health information, except in circumstances in which confidentiality is waived in accordance with Illinois and federal law.
- The right to request that communication of you health information be made by alternative means or at an alternative location by delivering the request in writing to my office.
- The right to receive an accounting of disclosures of your PHI that I make for purposes other than activities related to you treatment, our payment function, or other health care operation.
- The right to request that you health care record be amended to correct incomplete or incorrect information that I create in error.
- The right to receive communications of PHI in a confidential manner.

III. ILLINOIS INFORMATION DISCLOSURE WITHOUT YOUR CONSENT

Under Illinois and federal law, information about you may be disclosed without your consent in the following circumstances:

Child Abuse – If, as your clinician, I have reasonable cause to believe a child (known to me through a professional capacity) may be an abused child or neglected child, I am required by law to report this belief to the appropriate authorities.

(please turn over)

Elder Abuse – If, as your clinician, I have reason to believe that an elderly or disabled individual has been abused, neglected, or financially exploited, I must report this belief to the appropriate authorities.

Health Oversight Activities – I, as your clinician, may disclose protected health information regarding you to a health oversight agency for oversight activities authorized by law, including licensure of disciplinary actions.

Worker's Compensation – I may, as your clinician, 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.

Judicial and Administrative Proceedings – If you are involved in a court proceeding and any party requests information about your evaluation, diagnosis, or treatment, I, as your clinician, must release such information *if ordered by the court*. If you are being evaluated by a third party, or the evaluation itself is court ordered, I can release the information directly to you upon your request.

Serious Threat to Health or Safety – If you communicate a specific threat of imminent harm against yourself or another individual or if you believe that such a risk exists, I may make disclosures that I believe are necessary to protect you or that individual from harm.

Possession of Unregistered Firearms -- If you notify me that you possess illegal firearms, which are not registered in the state of Illinois, I must report this to the appropriate authorities.

IV. TO REQUEST INFORMATION TO FILE A COMPLAINT

If you are concerned that I have violated your privacy rights, or you disagree with a decision about access to your records, please bring this to my attention. Of, if you choose, you may contact a representative of my state professional organization. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

As a clinician, I support your right to protect the privacy of your medical information. I will not retaliate in any way if you choose to file a complaint.

V. ADDITIONAL INFORMATION ON CONFIDENTIALITY AND SECURITY

Access to your PHI is restricted. I maintain physical, electronic, and procedural safeguards that comply with federal regulation to guard your private information.

Note: I reserve the right to amend, change, or eliminate provisions in my privacy practices and access practices and to enact new provisions regarding the protected health information I maintain. If my information practices change, I will amend the Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of the "Notice" or by visiting my office.

I,_____, acknowledge that I have read and understand Michelle Heyden's Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act. I also understand that I can receive a copy of this document at any time.

_____

Signature of Client Date

_____

Signature of 2nd Client, if applicable Date

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Credit Card Information Sheet

As part of my standard procedure, your credit card information is kept on file for late cancellations, no-shows, or outstanding balances. You will be notified prior to any charges and will be given the option to pay in cash, check, or credit. If no response is received, you authorize Michelle Heyden to put any outstanding balance on this card. While payments in the form of cash or check are preferred, you can choose to utilize your credit card for regular session payments and will be asked to bring your card with you when you wish to use this form of payment. Please be assured that your credit card information will be treated with the same strict confidentiality practices as your health information. This form will be shredded when you graduate from treatment and outstanding balances have been paid. By signing this form you agree to the above conditions.

Client Name: _____

Name on Card: _____

Type: Visa MasterCard Discover Am/Ex

Number: _____

Expiration Date: _____

3 Digit CVS Code: _____

Billing Address for Card:

Street:_____

Zip Code:_____

Client Signature: _____

Additional notes:

_____

_____

_____