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REGISTRATION

CLIENT DEMOGRAPHICS (Self)

Legal Name:	**Today's Date:**
Last First M.I.	**Date of Birth:** Age:
Preferred Name:	**Marital Code:** __Single __Married __Divorced
Address:	__Separated __Remarried __Widowed
	Sex: __ Female __ Male
City State Zip	**Cell Phone number:**
Email:	May we leave voicemail? Yes ____ No ____
May we contact you via email? Yes ____ No ____	**Home Phone number:**
Occupation:	May we leave voicemail? Yes ____ No ____
Employer Name:	**Social Security Number:**
Employer Address:	**Primary Care Provider:**
Employer Phone:	
May we leave message? Yes ____ No ____	**Facility:**
Emergency Contact Name:	
Relationship to client:	**Address:**
Address:	
	City State Zip
City State Zip	**Phone:**
Phone(s): Cell_____ Home _____ Work _____	**Religion:**
How did you hear about us? __Family __Friend __Hospital __Doctor __Insurance Plan __Yellow Pages __Website __Facebook __Other	**Congregation:**

MINOR INFORMATION (if client is a Minor)

Name Of School:	**Grade/Level:**
Address:	**Phone:**
	School Contact:
City State Zip	**Title:**
Parent(s)/Guardian(s) Name:	**Parent/Guardian Cell Phone:**
Address:	**Parent/Guardian Home Phone:**
	Parent/Guardian Work Phone:
City State Zip	

GUARANTOR DEMOGRAPHICS *(Person(s) responsible for financial billing)*

Self: ☐ **Parent:** ☐ **Legal Guardian:** ☐ **Other:** ☐

Name:	**Date of Birth:**
Last First M.I.	**Phone number:**
Address:	**Social Security Number:**
	Relationship to client:
City State Zip	
Employer Name:	**Occupation:**
Employer Address:	**Employer Phone:**
City State Zip	

The above information is true to the best of my knowledge. I authorize Crossroads Counseling & Life Coaching or insurance company to release any information required to process my claims. I assign all payments for services rendered to myself or my dependents directly to Crossroads Counseling & Life Coaching. I understand that I am responsible for any balance or amounts not covered by insurance.

Initial _____

Vision Statement: To provide clear direction and empower clients physically, emotionally, and spiritually in their everyday lives.

CLIENT NAME: _____ **DATE OF BIRTH** _____

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS NOTIFICATION

I acknowledge that I have received the Crossroads Counseling & Life Coaching Notice of Privacy Practices and Client Rights either in- person or electronically.

Initial _____

NO SHOW AND CANCELLATION

I acknowledge that I have received the Crossroads Counseling & Life Coaching No Show/Cancelation Policy either in- person or electronically.

Initial _____

STATEMENT OF CLIENT FINANCIAL RESPONSIBILITY

I acknowledge that I have received the Crossroads Counseling & Life Coaching Statement of Client Financial Responsibility either in- person or electronically.

Initial _____

Signature: _____ Date: _____

A photocopy of this authorization and assignment shall be considered as valid as the origin.

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AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME:_____ **DATE OF BIRTH:**_____

I, _____, authorize ***Crossroads Counseling & Life Coaching*** to:
Client Name

CHECK ALL APPLICABLE> ☐ **Release to** ☐ **Request from** ☐ **Verbally exchange**

with the following facility or person:

Name: _____

Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Information Requested for service dates _____ **to** _____**:**

☐ All items in this section	☐ Financial	☐ Medical records
☐ AODA evaluation/treatment	☐ IEP's and school behavior records	☐ Psychiatric Medical Records
☐ Appointments	☐ Joint Sessions	☐ Psychological testing/evaluation
☐ Confirmation of Contact	☐ Phone/Email contact	☐ Psychotherapy notes

☐ Other: _____

Purpose of Release:

☐ Coordination of Care	☐ Further Medical Care	☐ Legal Investigation or Action
☐ Diagnostic Evaluation	☐ Insurance Eligibility/Benefits	☐ Treatment Planning

☐ Other: _____

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____.

Your Rights With Respect To This Authorization:

- Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.
- Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Expiration Date: I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. Unless revoked earlier, or otherwise specified above, this consent will expire in twelve (12) months from the date signed.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client: _____ **Date:** _____

Signature of Parent, Guardian or Authorized Person:_____ **Date:** _____

If signed by person other than patient, state relationship and authority to do so.

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**

Legal Authority: ☐ **Parent of minor** ☐ **Power of Attorney** ☐ **Next of kin (Spouse of living)** ☐ **Legal guardian (Attach proof)**

Employee Verification Initials: _____ **REV 4/25/23**

Vision Statement: To provide clear direction and empower clients physically, emotionally, and spiritually in their everyday lives.

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AUTHORIZATION FOR RELEASE OF INFORMATION

CLIENT NAME:_____ **DATE OF BIRTH:**_____

I, _____, authorize ***Crossroads Counseling & Life Coaching*** to:

Client Name

CHECK ALL APPLICABLE> ☐ **Release to** ☐ **Request from** ☐ **Verbally exchange**

with the following facility or person:

Name: _____

Facility: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Information Requested for service dates _____ **to** _____**:**

☐ All items in this section	☐ Financial	☐ Medical records
☐ AODA evaluation/treatment	☐ IEP's and school behavior records	☐ Psychiatric Medical Records
☐ Appointments	☐ Joint Sessions	☐ Psychological testing/evaluation
☐ Confirmation of Contact	☐ Phone/Email contact	☐ Psychotherapy notes

☐ Other: _____

Purpose of Release:

☐ Coordination of Care	☐ Further Medical Care	☐ Legal Investigation or Action
☐ Diagnostic Evaluation	☐ Insurance Eligibility/Benefits	☐ Treatment Planning

☐ Other: _____

The information to be released may include psychiatric, developmental disability, alcohol abuse, drug abuse, HIV test results, AIDS or AIDS related disease diagnosis unless specified: _____.

Your Rights With Respect To This Authorization:

- Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form.
- Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form.
- Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

Expiration Date: I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. Unless revoked earlier, or otherwise specified above, this consent will expire in twelve (12) months from the date signed.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Client: _____ **Date:** _____

Signature of Parent, Guardian or Authorized Person:_____ **Date:** _____

If signed by person other than patient, state relationship and authority to do so.

Patient is: ☐ **Minor** ☐ **Incompetent** ☐ **Disabled** ☐ **Deceased**

Legal Authority: ☐ **Parent of minor** ☐ **Power of Attorney** ☐ **Next of kin (Spouse of living)** ☐ **Legal guardian (Attach proof)**

Employee Verification Initials: _____

REV 4/25/23

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REFUSAL FOR DISCLOSURE OF HEALTH INFORMATION

_____ Please initial if you (or your child) have a Primary Care Physician and choose not to sign a release of information to the PCP.

_____ Please initial if you (or your child) have another behavioral health clinician (i.e. psychologist, psychiatrist, counselor) involved in your (or your child's) care and choose not to sign a release of information.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent/Guardian Date

_____ _____

Employee Verification Signature Date

REV: 4/12/23

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CLIENT FINANCIAL RESPONSIBILITY AGREEMENT

Client Name: _____ DOB: _____

COUNSELING FEE SCHEDULE:

SERVICE	Full Charge	Insurance Allowed Charge	Self Pay - due same day
Assessment (done at initial appt and annually)	$312	Determined by Insurance	$200
30 Minute Individual Counseling	$175		$90
45 Minute Individual Counseling	$188		$120
60 Minute Individual Counseling	$200		$150
60 Minute Family w/out Client Counseling	$175		$125
60 Minute Family w/Client Counseling	$200		$150
Materials Testing Fee - NOT reimbursed by ins	$50	NA	$50

STATEMENT OF CLIENT FINANCIAL RESPONSIBILITY:

- I understand the Materials Testing Fee of $50 required prior to first appointment for clients scheduled for psychological testing, neuropsychological testing, ADHD testing or Autism testing.
- I understand payment is due at the time of service, and I am ultimately responsible for payment of my bill.
- I understand that if Crossroads is unable to collect payment from the individual listed as the Guarantor (person(s) responsible for financial billing), I will be ultimately responsible for payment in full.
- I understand this responsibility obligates me to ensure payment in full of Crossroads' fees.
- I understand as a courtesy, Crossroads will verify my coverage and bill my insurance carrier.
- I understand it is my responsibility to obtain pre-authorization for services when required by my insurance carrier and to make Crossroads aware of this requirement.
- I understand I am responsible for payment of any deductible and co-payment/co-insurance as determined by my contract with my insurance carrier, and I am responsible for any amounts NOT covered by my insurer.
- I understand many insurance companies have additional stipulations that may affect my coverage.
- I understand that it is my responsibility to know whether my insurance requires a doctor's referral. If that is the case, it is my responsibility to coordinate the referral and provide Crossroads with the necessary information before my first appointment. Failure to provide a required referral may result in patient responsibility for all charges.
- I understand if my insurance carrier denies any part of my claim, or if my counselor or I elect to continue past my approved dates of service, I will be responsible for my balance in full.
- I understand that I must provide updated insurance information annually and/or if there are any changes in my insurer or policy information. I will be responsible for any charges due as a result of untimely filing caused by failure to provide this updated information to Crossroads.
- I understand if I do not have health insurance I will be financially responsible for services rendered at Crossroads Counseling & Life Coaching, LLC.
- I understand that Crossroads Counseling & Life Coaching, LLC does not accept Medicaid or any other state aid insurance policy.
- I understand that if I have a private insurance policy and Medicaid, I will be responsible for the balance due after my private insurance has been processed.
- **I understand that if I cancel my initial assessment appointment at any time after scheduling, I will be responsible for a $150 deposit to my account prior to rescheduling the assessment. This deposit will be applied to any out-of-pocket costs incurred on my account.**
- **I understand that if I give less than 24-hour notice, I am responsible for a cancellation fee of $100 for an appointment with a counselor and $135 for an appointment with a psychologist, which must be paid prior to the next scheduled appointment.**
- I understand there will be a $25.00 fee for all returned checks.
- I understand that if I request a copy of my medical records, a fee of $.25 per page or a maximum of $25.00 will be charged to compensate the office staff for their time, effort, and supplies.

CLIENT FINANCIAL RESPONSIBILITY AGREEMENT, continued – page 2 of 3

Client Name: _____ DOB: _____

- I understand that the clinicians at Crossroads Counseling and Life Coaching, LLC have a policy to not get involved in court cases if at all possible due to their focus on the therapeutic needs of their clients. If my reason for seeking services is to get professional testimony or written evidence for court proceedings, I should inform Crossroads Counseling and Life Coaching, LLC prior to my intake appointment so they can make an appropriate referral.
- I understand that if the clinicians at Crossroads Counseling and Life Coaching, LLC are subpoenaed for my legal issues (or the legal issues of my child), an out-of-pocket flat fee of $800 will be charged upfront to compensate the clinician on their time, energy, and preparation.
- I understand Crossroads reserves the right to seek legal means to secure reimbursement if financial arrangements are not met. This may include action through the Small Claims Court or a third- p a r t y collection agency.

I have read and agree to the above Statement of Financial Responsibility to Crossroads Counseling & Life Coaching, LLC, for providing mental/behavioral health services to me or the above-named client.

Client Initial: _____

NO SHOW/CANCELLATION POLICY:

- Counseling appointments range from 30 to 90 minutes in duration.
- I agree to attend all scheduled appointments. Crossroads' counselors reserve this time for your appointment.
- I understand I must provide **24-hour** notice if I need to cancel an appointment and not be charged.
- I understand the reminder call is a courtesy and I am still responsible to know when my appointment is.
- I understand that if I give less than 24-hour notice, I am responsible for a cancellation fee of $100 for an appointment.
- I understand insurance companies will not pay for missed appointments.
- I understand that if I am over 15 minutes late, my appointment may be cancelled, and I will be responsible for the cancellation fee of $100 which must be paid prior to my next scheduled appointment.
- I understand I will need to pay the cancellation fee in order to reschedule my appointment.
- I understand if I provide no notice of cancellation of an appointment, I will be responsible to pay the cancellation fee of $100 prior to my next scheduled appointment.
- Frequent cancellations will result in the loss of services.

I have read and agree to the above NO SHOW/CANCELLATIN POLICY for Crossroads Counseling & Life Coaching, LLC, in regards to providing mental/behavioral health services to me or the above-named client.

Client Initial: _____

CREDIT CARD ON FILE AGREEMENT: **NOTE for Telehealth Services** – client portion of fee is due at each date of service.

I authorize Crossroads Counseling & Life Coaching, LLC to retain my credit card on file with the secure payment processor, BillerGenie. I understand that I will need to provide a credit card on file for payment of the client portion of all telehealth services and may elect to have a stored credit card on file for all office services, also. I agree to have payments charged to my credit card at each date of service or per a separate authorized payment agreement with Crossroads Counseling & Life Coaching. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Crossroads Counseling & Life Coaching, LLC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

I have read and agree to the above CREDIT CARD ON FILE AGREEMENT for Crossroads Counseling & Life Coaching, LLC.
Client Initial: _____

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CLIENT FINANCIAL RESPONSIBILITY AGREEMENT, continued – page 3 of 3

Client Name: _____ DOB: _____

PAYMENT AGREEMENT

****NOTE: Social Security number required for: TriCare, Medicare, VA, and EAP****

CHOOSE YOUR PAYMENT METHOD **– Mark either Insurance (& Secondary Insurance, if applicable) OR Self-Pay:**

☐ **PRIMARY INSURANCE** (Card Copy Required):

Policy Holder: ☐ **Client** ☐ **Guarantor** ☐ **Other**	**Subscriber Cell Phone:**
Client Relationship to Subscriber:	**Subscriber Email Address:**
Subscriber Name (Policy Holder):	**Insurance Company:**
Subscriber Social Security #: **Subscriber Date of Birth (MM/DD/YYYY):**	**Insurance ID# or Medicare ID #:**
Subscriber Address:	**Insurance Group Number:**

☐ **SECONDARY INSURANCE** (Card Copy Required):

Policy Holder: ☐ **Client** ☐ **Guarantor** ☐ **Other**	**Subscriber Cell Phone:**
Client Relationship to Subscriber:	**Subscriber Email Address:**
Subscriber Name (Policy Holder):	**Insurance Company:**
Subscriber Social Security #: **Subscriber Date of Birth (MM/DD/YYYY):**	**Insurance ID# or Medicare ID #:**
Subscriber Address:	**Insurance Group Number:**

☐ **SELF PAY: (Due at each session / Telehealth Sessions need to have Credit Card on file)**
☐ **Credit Card** ☐ **Cash or Check**

☐ **CREDIT CARD ON FILE:**

Name on Card:	**Card Number:**
Expiration MM/YY:	**Zip Code:**

I have read and agree to the above Statement of Financial Responsibility, No Show/Cancellation Policy, Credit Card On File Agreement, and Payment Agreement regarding my financial responsibility to Crossroads Counseling & Life Coaching, LLC, for providing mental/behavioral health services to me or the above-named client.

Client Signature _____ Date _____

If guarantor is not the client, please sign below:

Guarantor Signature _____ Date _____ **REV 12/19/23**

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CLIENT INFORMED CONSENT, AGREEMENT, AND AUTHORIZATIONS

CLIENT NAME: _____ **DATE OF BIRTH:** _____

CLIENT AGREEMENT

I agree that during the time that I am an active client of Crossroads Counseling & Life Coaching, I will cooperate to the best of my ability to keep the company informed of my place of residence, employment status, and my progress. I understand that Crossroads Counseling & Life Coaching is open Monday through Thursday as designated as "Hours of Operation." If I need to reschedule an appointment, I will make every effort to call at least 24 hours in advance. If I provide less than 24 hours notice of a cancellation there will be a cancellation fee as described in the No Show/Cancellation Policy. If at any time I decide to stop treatment at this company, I agree to inform my therapist. I understand that my counselor is not available outside of business hours and does not use a business cell phone or check messages during non-business hours. If I am in crisis and my therapist cannot be reached at Crossroads Counseling & Life Coaching I can call 1-800-322-7143 after hours or 911. (_____)

INFORMED CONSENT FOR TREATMENT

I am aware that Crossroads Counseling & Life Coaching staff will conduct all or part of my care. I have been informed of services offered, and understand the risks and benefits inherent in the recommendations provided by Crossroads Counseling & Life Coaching. I understand my participation in treatment may generate stress and/or emotional discomfort as I address issues identified in treatment. I understand that my treatment plan may be revised periodically due to my progress or lack of progress. I recognize that the practice of mental health treatment is not an exact science, and therefore acknowledge that no guarantees have been or can be made regarding the likelihood of success or outcome of any treatment. I hereby consent to the treatment provided by Crossroads Counseling & Life Coaching and its employees or designees. I authorize the services deemed necessary or advisable by my caregivers to address my needs. I have proper legal status to give consent to treatment. (_____)

INFORMED CONSENT FOR EMAIL COMMUNICATIONS

I understand that all e-mail messages are sent over the internet and are not encrypted, are not secure, and may be read by others. I understand that my initial e-mail communications with Crossroads Counseling and Life Coaching staff will not be encrypted and, therefore, neither my counselor nor Crossroads can guarantee the confidentiality and security of any information I send to anyone at Crossroads or that they send to me via e-mail. I hereby give permission for all my present and future Crossroads counselors to reply to my messages via e-mail, including any information that they deem appropriate, that would otherwise be considered confidential. I agree that Crossroads and any employees or agents of Crossroads shall not be liable for any breach of confidentiality that may result from this use of e-mail via the internet. I understand that e-mail communication should not be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If I believe I need a response within 48 hours, I will not use e-mail but will call Crossroads Counseling and Life Coaching. If I do not receive an answer to a routine e-mail message within two working days, I understand that I should call Crossroads. I understand that all email communications may be made part of my permanent medical record and would be accessible to all current and future Crossroads counselors and staff involved in my care. I also understand that I may withdraw permission for counselors to communicate with me via e-mail by notifying my counselor in writing. (_____)

INFORMED CONSENT FOR TELEPSYCHOLOGY SERVICES

I am aware there are potential benefits and risks of telepsychology (e.g. limits to patient confidentiality) that differ from in-person sessions. There are inherent risks associated with video conferencing and the use of third party service-providers (i.e. computer IP addresses, smart phone location services, phone numbers, etc. may be retained by third party service providers). Confidentiality still applies for telepsychology services, and recording sessions is not permitted by the client or clinician.

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CLIENT INFORMED CONSENT, AGREEMENT, AND AUTHORIZATIONS, continued – Page 2 of 2

CLIENT NAME: _____ **DATE OF BIRTH:** _____

Crossroads Counseling agrees to use the video-conferencing platform selected for our virtual sessions, and the clinician or office staff will explain how to use it. I will need to use a webcam or smartphone during the session, or a telephone. It is important to be in a quiet, private space that is free of distractions (including cell phones and other devices) during the session. It is important to use a secure internet connection rather than public/free Wi-Fi. It is important to be on time. If I need to cancel or change my tele-appointment, I must notify the office sooner than 24 hours before my scheduled appointment. I will need a back-up plan (e.g., phone number where I can be reached) to restart the session or to reschedule it, in the event of technical problems. If I am not an adult, my parent or legal guardian will need to provide permission and their contact information for me to participate in telepsychology services. I should confirm with my insurance company that the video sessions will be reimbursed; if sessions not reimbursed, I am responsible for full payment. My clinician may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person once able to, until then a delay to therapy may be instilled or special arrangements may need to be made. (_____)

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my care, or for purposes of conducting the healthcare operations of Crossroads Counseling & Life Coaching. I authorize Crossroads Counseling & Life Coaching to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Crossroads Counseling & Life Coaching may release the minimal necessary amount of objective clinical information related to my diagnosis and treatment which may be requested by my insurance company or its designed agent. (_____)

ASSIGNMENT OF INSURANCE BENEFITS/PAYMENT GUARANTEE/COLLECTION FEE

I authorize payment to be made directly to Crossroads Counseling & Life Coaching for insurance benefits payable to me. I understand that I am financially responsible to Crossroads Counseling & Life Coaching at the time of service for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and requires collection, I am responsible for the cost of collection including attorney fees and a limited amount of information about treatment will have to be shared with the attorney (i.e. treatment dates and times). (_____)

PRIVACY POLICY

I have received a copy of the clients' Notification of Privacy Practices, Clients Rights, and Responsibilities. The information was explained using language that I understand. I acknowledge I have been offered my rights with verbal explanation, including the right to see and copy my records, to limit disclosure of my health information, and to request an amendment to my record, as explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Crossroads Counseling & Life Coaching has already made disclosure with my prior consent. (_____)

_____ _____

Client's Signature Date

_____ _____

Parent/Authorized Person's Signature Date

_____

Relationship to client

_____ _____

Employee Verification Signature Date

REV 4/12/23

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LIMITS OF CONFIDENTIALITY

Under certain legally defined situations, I am required to report information revealed during the course of counseling to other agencies or persons without your written consent. Every effort would be made to discuss this with you, should a situation arise. In emergency situations this cannot be guaranteed, however.

1. If you reveal information to me about child or elder abuse or neglect, I am required by law to report this to the appropriate authority.

2. If you are a clear or present danger to yourself or others, I am required by law to report this to the appropriate authority.

3. If you report sexual exploitation by another counselor or therapist, I may be required to notify the appropriate authority.

4. If you are in counseling or being tested by order of a court of law, the results of treatment or test ordered must be revealed to that court.

5. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.

6. In accordance with 2013 Illinois State Law, if you are diagnosed with a severe intellectual or developmental disorder that constitutes a substantial disability, I am mandated to report to the Illinois Department of Human Services.

I have read (or have had read to me) the above limits of confidentiality. I have a full understanding of their meaning and consequences. I agree to these limits of confidentiality.

_____
Printed name of Client

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Therapist Date

NOTES:

1. If client is under 12, parent/guardian sign.
2. If client is between 12-18, parent/guardian and client sign.
3. If over 18, client sign.
4. A copy of this form will be kept in the client's record.

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INTAKE QUESTIONNAIRE

Client Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

Who lives in the household with you now? _____

In your own words, tell me why you are here: _____

_____

_____

_____

Please estimate the severity of your problem by choosing an item from the list:

__Mild __Moderate __Severe __Extreme __Incapacitating

EMPLOYMENT

Occupation: _____ Company Name: _____

Employment: __ Full Time __ Part Time __Unemployed

How long have you been working there? _____ How many jobs have you worked in the past 3 years? _____

Are you presently receiving SSI or Workman Compensation, or Disability? __Yes __No

YOUR FAMILY OF ORIGIN

What town was client born: _____ Where was client raised: _____

Parent/Stepparent Name	Age	Educ. Level	Occupation	Marital Status
_____	____	_____	_____	__Single __Married __Divorced
_____	____	_____	_____	__Single __Married __Divorced
_____	____	_____	_____	__Single __Married __Divorced
_____	____	_____	_____	__Single __Married __Divorced

Brother/Sister Name	Sex	Age	Educ. Level	Occupation	Marital Status
_____	__Female __Male	____	_____	_____	__Single __Married __Divorced
_____	__Female __Male	____	_____	_____	__Single __Married __Divorced
_____	__Female __Male	____	_____	_____	__Single __Married __Divorced
_____	__Female __Male	____	_____	_____	__Single __Married __Divorced

Did you meet your developmental milestones? __Yes __No

If not, please explain: _____

_____

_____

EDUCATION

Highest Level of Education Completed: __Middle School __High School __Voc/Tech __College __Graduate

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INTAKE QUESTIONNAIRE, continued – page 2 of 5

CLIENT NAME:_____ **DATE OF BIRTH:**_____

CURRENT FAMILY

Name of Spouse(s)	Age	Date of Marriage	Date Ended	How Ended	Occupation

Children's Name	Sex (Female or Male)	Age	Education	Marital Status (Single, Married or Divorced)	Health Level (Poor, Aver., Above Aver., Excellent)

If shared custody – please list percentage of custody for children: _____

Please describe your religious/spiritual beliefs (if any): _____

Would you like your counselor to pray with you? __ Yes __ No

MILITARY HISTORY

Did you serve in the military? __ Yes __ No If yes, which service branch: _____Dates of service:_____

Type of Discharge: __Honorable __Dishonorable __Other

Did you experience medical, emotional, legal, or behavioral problems while in the service? __ Yes __ No

MEDICAL HISTORY

Do you or your child have a Primary Care Physician/Health Care Provider? __ Yes __ No

Primary Physician/Clinic:_____ Physician Phone Number: _____

Date of last Physical Exam:_____ Rate your health: __Poor __Good __Very Good __Excellent

Do you have any medical problems at this time? __ Yes __ No Please explain: _____

Head injuries or loss of consciousness: __ Yes __ No If yes, how many times:_____ Last time occurred: _____

Seizures __ Yes __ No If yes, frequency:_____ Length of time it lasts:_____ Occurring for how long:_____

Pregnancy & Delivery complication: __ Yes __ No If yes, please explain: _____

Allergies: __ Yes __ No __Unknown If yes, to what:_____

Sleep routine: # hours/night total_____; time to attain sleep state _____minutes; awake more than once/night? __ Yes __ No

Diet: meals_____x/day; ☐ partial or ☐ full meals; ☐ healthy or ☐ fast food

CLIENT NAME:_____ **DATE OF BIRTH:**_____

Please list medications you are currently taking:

Medication Name	Dosage	Start Date

Please list:

Medical Conditions	Diagnosis Date

Please list:

Drug Allergies, Food Allergies, Adverse Reactions	

MENTAL HISTORY

Have you ever met with a therapist before? __ Yes __ No If so, with whom and when: _____

If yes, was it a positive experience? __ Yes __ No

Are you currently seeing another behavioral health clinician (i.e., psychologist, psychiatrist, counselor)? __ Yes __ No

If yes, please list name and phone number: _____

Have you ever been hospitalized for mental health reasons? __ Yes __ No. When: _____

Please state previous diagnoses received: _____

_____

*Have you ever felt like hurting yourself or tried to hurt yourself or someone else? __ Yes __ No Recently felt this way? __ Yes __ No

If yes, please explain: _____

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INTAKE QUESTIONNAIRE, continued – page 4 of 5

CLIENT NAME:_____ **DATE OF BIRTH:**_____

FAMILY EMOTIONAL or MEDICAL – Mark below for any family members with these emotional or medical problems:

Mark an 'X' in all appropriate boxes.	Your Family					Your Mother's Family					*Your Father's Family*				
	Bio-Mother	Bio-Father	Step-Parent	Brothers	Sisters	Grandmother	Grandfather	Step-G.Parent	Uncles	Aunts	Grandmother	Grandfather	Step-G.Parent	Uncles	Aunts
Depressed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anger Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Emotional Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Legal Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heavy Drinking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Hospitalization	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Severe Medical Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Early Death	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

PRESENTING PROBLEMS/ISSUES: Check all that apply below that have occurred in the past six months.

- ☐ Aggressive behaviors
- ☐ Irritable or on edge
- ☐ Argues with others at home or work
- ☐ Difficulty paying attention/easily distracted
- ☐ Difficulty staying on task
- ☐ Doesn't finish tasks
- ☐ Poor concentration/focus
- ☐ Poor judgment/decision making
- ☐ Impulsive
- ☐ Hyperactive...difficulty sitting still
- ☐ Often fidgets
- ☐ Need to repeat when asked to do something
- ☐ Anxious
- ☐ Worries or ruminates
- ☐ Tearful/Cries easily
- ☐ Sensitive to what others say (re: them)
- ☐ Hair twirling/pulling
- ☐ Panic attack(s)
- ☐ Avoids certain activities or places
- ☐ Engages in repetitive behaviors
- ☐ Perfectionist
- ☐ Does not adjust easily to change
- ☐ Shy around strangers
- ☐ Does not have friends
- ☐ Trouble fitting in with Peers
- ☐ Socially awkward or anxious
- ☐ Gets teased or bullied
- ☐ Procrastinates
- ☐ Moody
- ☐ Depressed
- ☐ Very happy without cause
- ☐ Does not seem to have fun
- ☐ Has extreme fears or phobias
- ☐ Has threatened to hurt self
- ☐ Has talked about killing self
- ☐ Has engaged in self-injurious behavior
- ☐ Has attempted suicide
- ☐ Has difficulty falling asleep
- ☐ Has difficulty staying asleep
- ☐ Has nightmares or night terrors
- ☐ Lies or misleads others
- ☐ Steals
- ☐ Substance abuse
- ☐ Others think you Drink/use drugs too much
- ☐ Sexually acting out
- ☐ Appetite/weight change
- ☐ Eating issues (over/under eating, throws up)
- ☐ Low self-image / self-esteem
- ☐ Does not think any one likes you
- ☐ Has excessive amounts of energy
- ☐ Poor hygiene
- ☐ Upset by family conflict
- ☐ Doesn't get along with others
- ☐ Often takes too many risks
- ☐ Memory difficulties
- ☐ Works too much/too hard
- ☐ Over-reacts towards others
- ☐ Swears at people, things, situations
- ☐ Disrespectful to others
- ☐ Skips work
- ☐ Poor School/Job Performance
- ☐ Argue that you are always right
- ☐ Negative outlook on life
- ☐ Life stressors
- ☐ Recently experienced death of loved one
- ☐ Recently lost or changed jobs
- ☐ Recently moved from home
- ☐ Recently changed schools
- ☐ Marriage
- ☐ Divorce/Separation
- ☐ Relationship Problems
- ☐ Difficult Life Transition
- ☐ Family Medical Issues
- ☐ Legal/Court Issues
- ☐ Personal Medical Issues
- ☐ Retirement

Feelings often experienced:

☐ Bored	☐ Panicky	☐ Frustrated
☐ Annoyed	☐ Regretful	☐ Confused
☐ Guilty	☐ Sad	☐ Restless
☐ Unhappy	☐ Helpless	☐ Hopeless
☐ Hopeful	☐ Energetic	☐ Envy
☐ Lonely	☐ Anxious	☐ Relaxed
☐ Hurt	☐ Worthless	☐ Other

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INTAKE QUESTIONNAIRE, continued – page 5 of 5

CLIENT NAME: _____ **DATE OF BIRTH:** _____

SUBSTANCE USE / ABUSE

How often/much do you drink alcohol:

_____

How often/much do you use illegal substances:

_____

Do you smoke? __ Yes __ No If yes, how often/much: _____

Within the last 30 days (To respond YES, please click the box) -

1. Have you used more than you intended to in the last month?	__ Yes __ No
2. Has anyone told you that you should change how you use/drink?	__ Yes __ No
3. Have you missed out on important engagements (school, work, family functions) because of your use?	__ Yes __ No
4. Do you have cravings or urges to use?	__ Yes __ No
5. Have you noticed it takes more substances/alcohol than in the past to reach your desired effect?	__ Yes __ No
6. Have you experienced withdrawal symptoms when you have stopped using substances (headaches, stomach aches, irritability, shakiness, nausea/vomiting)?	__ Yes __ No
7. Have you struggled to recall what you have done while under the influence of substances/alcohol?	__ Yes __ No

Other information that may be helpful for us to know: _____

_____

Adverse Childhood Experiences Scale: The self-administered ACEs questionnaire below consists of ten questions intended to identify traumatic events involving abuse, neglect, and household dysfunction experienced during childhood (prior to age 18).

Please check box for all 'YES' answers:

1. Did a parent or other adult in the household often...swear at you, insult you, put you down, or humiliate you? Or Act in a way that made you afraid that you might be physically hurt?	__ Yes __ No
2. Did a parent or other adult in the household often push, grab, slap, or throw something at you? Or Ever hit you so hard that you had marks or were injured?	__ Yes __ No
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? Or Try to or actually have oral, anal, or vaginal sex with you?	__ Yes __ No
4. Did you often feel that ...No one in your family loved you or thought you were important or special? Or Your family didn't look out for each other, feel close to each other, or support each other?	__ Yes __ No
5. Did you often feel that ...You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it	__ Yes __ No
6. Were your parents ever separated or divorced?	__ Yes __ No
7. Was your mother or stepmother: Often pushed, grabbed, slapped, or had something thrown at her? Or Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife? ?	__ Yes __ No
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	__ Yes __ No
9. Was a household member depressed or mentally ill or did a household member attempt suicide?	__ Yes __ No
10. Did a household member go to prison?	__ Yes __ No
Total "Yes" answers: (This is your ACE Score)	_____

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

CLIENT NAME:		DATE:	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to doa task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoidor delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you haveto sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring ordifficult project?					
8. How often do you have difficulty keeping your attention when you are doing boringor repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in whichyou are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have timeto yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishingthe sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations whenturn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

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Burns Anxiety Inventory

Name_____ **Date**_____

DOB _____

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 33 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot
	Category I: Anxious Feelings				
1.	Anxiety, nervousness, worry, or fear.				
2.	Feeling that things around you are strange, unreal or foggy.				
3.	Feeling detached from all or part of your body.				
4.	Sudden unexpected panic spells.				
5.	Apprehension or a sense of impending doom.				
6.	Feeling tense, stressed, "uptight", or on edge.				
	Category II: Anxious Thoughts				
7.	Difficulty concentrating.				
8.	Racing thoughts or having your mind jump from one thing to the next.				
9.	Frightening fantasies or daydreams.				
10.	Feeling that you're on the verge of losing control.				
11.	Fears of cracking up or going crazy.				
12.	Fears of fainting or passing out.				
13.	Fears of physical illnesses or heart attacks or dying.				
14.	Concerns about looking foolish or inadequate in front of others				
15.	Fears of being alone, isolated, or abandoned.				
16.	Fears of criticism or disapproval.				
17.	Fears that something terrible is about to happen.				

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Burns Anxiety Inventory, continued – Page 2 of 2

Name_____ **Date**_____

DOB _____

	Category III: Physical Symptoms				
18.	Skipping or racing or pounding of the heart (sometimes called "palpitations")				
19.	Pain, pressure, or tightness in the chest.				
20.	Tingling or numbness in the toes or fingers.				
21.	Butterflies or discomfort in the stomach.				
22.	Constipation or diarrhea.				
23.	Restlessness or jumpiness.				
24.	Tight, tense muscles.				
25.	Sweating not brought on by heat.				
26.	A lump in the throat.				
27.	Trembling or shaking.				
28.	Rubbery or "jelly" legs.				
29.	Feeling dizzy, light-headed, or off balance.				
30.	Choking or smothering sensations or difficulty breathing.				
31.	Headaches or pains in the neck or back.				
32.	Hot flashes or cold chills.				
33.	Feeling tired, weak, or easily exhausted.				
TOTAL					

Add up your total score for the 33 symptoms and record it here: _____

Scoring Key for the Burns Anxiety Inventory	
Total Score	**Degree of Anxiety**
0 – 4	Minimal or No Anxiety
5 – 10	Borderline Anxiety
11 – 20	Mild Anxiety
21 – 30	Moderate Anxiety
31 – 50	Severe Anxiety
51 – 99	Extreme Anxiety or Panic

Scoring Key for the Burns Anxiety Inventory	
Total Score	**Degree of Anxiety**
If your anxiety is above **Mild Anxiety**, you should take action to protect yourself.	

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Burn's Depression Checklist

Name: _____ Date: _____

DOB: _____

	Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.	0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1---25 Here:					

TOTAL SCORE	LEVEL OF DEPRESSION
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

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NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Crossroads Counseling & Life Coaching respects client confidentiality and only releases confidential information about you in accordance with the Illinois and Federal laws. This notice describes our policies related to the use of the records of your care that have been generated by this Agency.

PRIVACY CONTACT: If you have any questions about this policy or your rights, please feel free to contact Rebecca Mowers, Privacy Officer for Crossroads at (309) 343-0800.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your protected health care information with others beyond our Agency. This includes:

TREATMENT- With your written consent, we may use or disclose private health care information about you to provide, coordinate or manage your care or any related services, including sharing information with others outside our Agency that we are consulting with or referring you to, such as your primary care physician or psychiatrist.

PAYMENT- With your written consent, information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

HEALTHCARE OPERATIONS- We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, or training staff.

Information Disclosed Without Your Consent. Under Illinois and/or Federal Law, information about you may be disclosed without your consent in the following circumstances:

EMERGENCIES- Sufficient information may be shared to address the immediate emergency that you are facing.

FOLLOW UP CARE/APPOINTMENTS- We may be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will leave appointment information on your answering machine unless you tell us not to.

AS REQUIRED BY LAW- Information may be shared in situations where we have a subpoena, court order, or are mandated to report protected health information such as suspected abuse or neglect, serious intended harm to self or others, or when a client has a mental disability as described in section 1.1 of the Firearm Owners Identification Card Act.

CORONERS- We are required to disclose information about the circumstances of your death to a coroner who is investigating it.

GOVERNMENTAL REQUIREMENTS- We may disclose information to health oversight agencies for activities authorized by law such as audits, investigations, inspections, and licensure. We are also required to share information, if requested, with the US Department of Health and Human Services to determine our compliance with Federal laws related to health care and to Illinois state agencies that fund our services.

CRIMINAL ACTIVITY OR DANGER TO OTHERS- If a crime is committed on our premises or against our personnel; we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement when we believe an immediate danger may occur to someone.

CLIENTS RIGHTS

You have the following rights under Illinois and/or Federal law:

All information concerning you is held confidential and released only through procedure consistent with the Mental Health & Developmental Disabilities Confidentiality Act (740ILCS 110 et seq), Confidentiality of Alcohol and Drug Abuse Patient records regulations (42 CFR 2 (1987), and professional ethics.

Crossroads Counseling & Life Coaching staff recognize written policies and procedures controlling access to records and information governed by the AIDS Confidentiality Act (410ILCS305) (AIDS Act) and the AIDS Confidentiality and Testing Code (ILL Adm. Code 697) (AIDS Code).

NOTICE OF AVAILABILITY OF GOOD FAITH ESTIMATE - You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit 222.cms.gov/nonsurprises or call (309) 343-0800.

COPIES OF RECORDS- You have the right to review and copy protected health care information in your record that is generated by Crossroads Counseling & Life Coaching. The original record is the property of Crossroads Counseling & Life Coaching. We may charge you a reasonable fee for copying and mailing your records which will be paid prior to receipt of requested copies.

RELEASE OF RECORDS- You may consent in WRITING to release your records to others, for any purpose you choose. This could include your attorney, employer, or others you wish to have knowledge of your care. You may revoke this consent in writing at any time, but only to the extent no action has been taken in reliance on your prior authorization.

RESTRICTION ON RECORD- You may ask us not to use or disclose part of your protected health information. This request must be in writing and should be given to your counselor. Crossroads Counseling & Life Coaching is required to agree with your request if it fits within the requirements of the HITECH Act.

CONTACTING YOU- You may request that we send information to another address or by alternate means. We will honor such request as long as it is reasonable and we are assured that it is correct. We have the right to verify that the payment information you are providing is correct. Email and faxes are not guaranteed to be secure methods of communication. The staff at Crossroads Counseling & Life Coaching will not use these methods regarding protected health care information unless there is a signed release.

AMENDING RECORDS- If you believe that something in your records is incorrect or incomplete, you may request we amend it. To do this contact your counselor and ask for the *Request to Amend Protected Health Information* form. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement of disagreement with us. We will then file our response and your statement and our response will be added to your records.

ACCOUNTING FOR DISCLOSURES- You may request an account of any disclosures we have made related to your protected health care information. Exceptions to your request include information we shared with you about you or information you gave a specific consent to release and information that we were required to release as previously listed. To receive information regarding disclosures made for a specific six year time period prior to your request and after April 14, 2003, please submit your request in writing to your specific counselor. We will notify you of the cost involved in preparing this list which is required to be paid prior to receipt of requested information.

QUESTIONS AND COMPLAINTS- If you have any questions, want a copy of this Policy, or have complaints, you may contact Crossroads Counseling & Life Coaching in writing at 575 N Kellogg St., Galesburg, Il 61401 for further information. You also may contact the Secretary of US Department of Health and Human Services if you believe Crossroads Counseling & Life Coaching has violated your privacy rights. We will not retaliate against you for filing a complaint.

GRIEVANCE PROCEDURE- If at any time you feel you are not being treated fairly, you should discuss it with your therapist. If a grievance remains unresolved with your therapist, a written description may be submitted to the Directing Members of Crossroads Counseling & Life Coaching for further review. A written response will be returned to the client within 30 days from submission. External resources are available upon request. No client will be denied, suspended, or terminated from service, or have services reduced for filing a grievance or exercising any rights.

CHANGES IN POLICY- Crossroads Counseling & Life Coaching reserves the right to change its Privacy Policy based on the needs of Crossroads Counseling & Life Coaching and changes in the state and federal law.

CLIENT RIGHTS STATEMENT

As a client of Crossroads Counseling & Life Coaching you have the following rights:

1) To not be denied services on the basis of age, sex, race, religious beliefs, ethnic origin, marital status, physical or mental disability, sexual orientation, HIV status, or criminal record. You have the right to nondiscriminatory access to services as specified in the American's with Disability Act of 1990 (42 USC 12101).
2) To services provided in the least restrictive environment available for your needs pursuant to an individual treatment plan. You have the right to be free from abuse or neglect. Crossroads Counseling & Life Coaching, L.L.C. specifically prohibits psychological, sexual, and physical abuse and punishment. Crossroads Counseling & Life Coaching does not utilize seclusion/restraint as a form of treatment.
3) To designate a representative decision-maker in the event that you are incapable of understanding a proposed treatment. The representative decision-maker will participate throughout the development and implementation of the Individual Treatment Plan.
4) To confidentiality of your status and records, including HIV status and testing as provided for under Illinois law.
5) To not be presumed legally disabled unless declared so by a court.
6) To give an informed consent to treatment. You also have the right to refuse treatment and to be told the consequences of such refusal. This could include Crossroads Counseling & Life Coaching being unable to provide services to you.
7) If you believe your rights have been violated, you have the right to contact any of the groups listed in the previous information.
8) If you have a complaint about the services provided, you may file a grievance by following the *Grievance Procedure* outlined in the previous information.

CLIENT RESPONSIBILITIES

As a client of Crossroads Counseling & Life Coaching you have the following responsibilities:

1) To keep appointments as scheduled, and notify Crossroads Counseling & Life Coaching at least 24 hours in advance of scheduling changes. Crossroads Counseling & Life Coaching has office hours as follows: 9:00 a.m. – 5:00 p.m. Monday through Wednesday, 9:00a.m.-6:00p.m. on Thursday, and by counselors' appointment on Friday. Other appointment times are available by special arrangement. The phone number for after hour emergency calls is 1-800-322-7143 or you can go to your local hospital Emergency Department.
2) To communicate openly, honestly, and respectfully regarding all information related to treatment.
3) To notify the office of any changes in address, telephone number, employment status, or insurance company coverage.
4) The staff at Crossroads Counseling & Life Coaching recognizes the risks involved with alcohol and other drug use. You will be asked to abstain from alcohol and other mood altering drugs not prescribed by your physician. It is very important that you discuss with your therapist any prescribed or over-the-counter medications you are taking.

MUTUAL RESPONSIBILITES OF CROSSROADS COUNSELING & LIFE COACHING AND CLIENT

As a client of Crossroads Counseling & Life Coaching we share in the following responsibilities:

1) Deciding on the most appropriate treatment approach for you.
2) Determining the treatment plan, including the frequency and duration of client involvement.
3) Involving family member(s) or significant others in treatment as needed.

CROSSROADS COUNSELING & LIFE COACHING RESPONSIBILITES

To our clients, Crossroads Counseling & Life Coaching has the following responsibilities:

1) To assign a therapist. He/She will work with you to help you reach your treatment goals. There may be times your primary therapist is not available, and other staff will be available to assist you if needed. If you need services outside our practice, your therapist will help you make the appropriate contact. If you have any questions or need assistance, you should contact your primary therapist.

2) To provide you with the credentials of the counselor responsible for your care upon your request. Each counselor has their license and certificates displayed in their individual offices.
3) To maintain accurate clinical records.
4) To refer and link to other service providers, as appropriate. Clients may be referred to their primary care physicians or psychiatrist for medication assessment as determined by you and/or your therapist. If you have not had a recent physical examination, you may be asked to do so.
5) To bill and collect for services provided.
6) To communicate with courts as mandated by Statute, Rule, or Court decision.
7) To limit services based on the funding that we receive. This may require us to prioritize services based on severity of your service needs. Services are charged based on the cost of providing those services.
8) To guarantee the right to contact Equip for Equality and the Department of Human Services as appropriate. These numbers are available upon request.

Effective 09/01/2008

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