



Today's Date: _____
 Therapist: _____
 Dx: _____

NEW CLIENT INFORMATION

Client's Full Legal Name: _____ DOB: _____

Address: _____ Patient Gender M F

City: _____ ST: _____ ZIP: _____ Marital Status: Single Married Divorced Widowed

Phone (H): _____ Ok to leave a message Y N (C): _____ Ok to leave a message Y N

Email Address: _____ Ok to send messages Y N

Patient Appointment Reminders: Stenzel offers appointment reminders through text messages or email; your normal cell charges will apply. I consent for Stenzel Clinical Services to send appointment reminders using:

Text Cell Phone: _____ Email _____ Both

Family Member Names	Date of Birth	Relationship	Phone Number and/or Email Address

How were you referred to Stenzel Clinical Services? Insurance Physician School Church Friend Google
 Other: _____

INSURANCE INFORMATION

I understand, and agree that, (regardless of insurance policy). I am responsible for the entire balance on my account, I understand that I am required to render payment for any current and past due balances at the time of service, this includes co-payments, missed appointment fees, co-insurance, or any balances that are the responsibility of the client, or client's parent or guarantor/insured.

Please present insurance card at first visit.

If insurance is not being used, please check here.

Primary Insurance Co. Name: _____

Subscriber's Name: _____ Relationship to client: Self Spouse Parent Other _____

Address of Subscriber _____
 (If different than above) _____ City _____ ST _____ Zip _____

Secondary Insurance Co. Name: _____

Subscriber's Name: _____ Relationship to client: Self Spouse Parent Other _____

Address of Subscriber _____
 (If different than above) _____ City _____ ST _____ Zip _____

GUARANTOR INFORMATION

(Person who is financially responsible if different from patient above.)

Name: _____ DOB: _____

Address: _____
 _____ City _____ ST _____ Zip _____

Relationship to Client: Spouse Mother Father Other (relationship) _____

Phone (H): _____ Ok to leave a message Y N (C): _____ Ok to leave a message Y N

Email Address: _____ Ok to send messages Y N

I hereby consent for Stenzel Clinical Services to contact the person(s) below as deemed necessary regarding the information indicated. This consent shall remain in force during my treatment at Stenzel Clinical Services and for 90 days following my last visit or after services have been paid in full unless expressly revoked by me in writing.

Name	Relationship	Phone	Email	Ok to leave messages	Financial info.	Other
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____
_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____



INFORMED CONSENT

We would like you to have a clear understanding of the services we provide and our expectations of you, our client. If you have questions or need clarification, please ask your therapist for assistance before you sign.

Services Offered

Stenzel Clinical Services, Ltd. Provides outpatient counseling services. We work with all age groups. Licensed practitioners provide individual, group, couples and family counseling, as well as case coordination.

We strive to return all messages as quickly as possible Monday through Friday. Routine messages left on the weekend may be returned Monday. We do not guarantee 24-hour crisis coverage and if your therapist is not available when you feel you are in crisis, please call DuPage Crisis line at 630-627-1700, proceed to your local hospital emergency room, or call 911.

Initial Assessment, Diagnosis, and Counseling Process

Initial assessments take place at the first appointment. These appointments are used to gather data, complete intake information, and to determine the best course of care. A diagnosis will be given for each client being seen, just as with a visit to a medical doctor.

If ongoing counseling is recommended, we will diligently work to provide the best therapeutic methods and tools available. For counseling to be successful, your commitment to the process is essential. This includes regular attendance and active participation, homework between sessions to enhance or speed your growth, and completion of the process through planned termination of counseling services. You may begin to find some relief of symptoms initially, and it may be tempting to terminate. However, this initial relief is often temporary if counseling is stopped abruptly. Because all therapists want to see you have the greatest growth possible during the time you are here, we will work with you to plan a successful wrap-up. This is an important part of the counseling process, and we highly encourage you to honor your own effort by not neglecting this phase.

Fees and Insurance

Initial assessments are \$160. Standard sessions are \$135. Telephone consults less than 10 minutes are complementary if not overused. Phone sessions that last more than 10 minutes will be charged to the client directly, as phone sessions are not covered by insurance. Phone session are the same cost as office sessions. Payment is due at the time of service. Any checks returned by the bank will incur a fee. Any balances unpaid after 90 days will be forwarded to collections. All accounts forwarded to collections will incur a 25% Collection Fee. Continued non-payment will result in a report to the credit bureau and remain until the balance has been paid in full. We bill most insurance as a courtesy to you. If we are unable to bill your insurance company, you will be considered a Self-Pay client and must pay the full fee at the time of session. You will be given a receipt for your session, which you may use to request reimbursement from your insurance company. If you receive an insurance payment meant for us we ask that you send payments to us immediately.

Cancelled or Missed Appointments

Due to the nature of counseling services, we never overbook our schedules. We require 24-hours notification of cancellation. We charge an \$85 Cancellation Fee for any appointment not cancelled 24-hours in advance. If you are more than 20 minutes late for your scheduled appointment you may be asked to reschedule for another day and you will be charged the \$85 Cancellation Fee. Insurance companies will not cover missed appointment fees. These fees are immediately due by you. Please note that two or more instances of missed appointments without notifying your therapist may result in termination of services. In the event of inclement weather, as determined by the local school district, the cancellation fee may be waived. To have your fee waived you must contact the office prior to your appointment to notify the therapist that you will not arrive due to inclement weather. You are financially responsible for the time you have reserved with your therapist. You will be billed for any services not covered by insurance.

Confidentiality

Legal and ethical standards require us to maintain confidentiality. Information cannot be divulged to any outside parties without your written consent with the following exceptions: if you are or become a danger to yourself or others, we become aware of any real or alleged abuse to children, elderly, or incapacitated people (in which case we are mandated reporters of the State of Illinois), and if we receive a properly issued subpoena accompanied by a court order to produce records.

If your therapist receives clinical supervision, s/he will inform you of that process. If you are here with family members, your therapist will discuss expectations and limitations of confidentiality.

Transfer Plan

In the event of incapacitation, death, or termination of a therapist's practice at Stenzel Clinical during your care, your records will remain in our possession and a new therapist will be made available to you. If you desire to transfer care outside of our practice, you may sign a release of records and we will release a standard extract from your file to the initial intake and most recent progress notes. It is our standard policy to release records directly to another provider. Any variance will be arranged by the Director/designee.

Notice of Privacy Policies and Clients Rights

I hereby acknowledge that I have been offered the "Notice of Privacy Policies and Clients Rights."

Agreement I have read and understand the above statement on services, policies, and procedures. My signature below indicates that I give my full consent to receive services at Stenzel Clinical Services, Ltd.

Client Signature (age 17 & over) _____ Date _____

Client Signature (age 12-16) _____ Date _____

Client guardian (for minors) _____ Date _____



The following questions are designed to help me understand your background. Please complete them as they apply to you. Thank you.

Highest education completed: High School/GED Some College College Graduate/Other

Is there a racial or ethnic group you identify with that you'd like me to be aware of? _____

Do you consider your spiritual life a resource? Y N

What is your religious affiliation (optional) _____ Attendance: Regularly Sometimes Never

Parent's Names: (F) _____ Age _____ Deceased ___

(M) _____ Age _____ Deceased ___

Number of brothers _____ sisters _____

Has anyone in your family of origin had counseling? Y N If yes, for what? _____

Is there any history of drug or alcohol abuse in either of your parent's families? Y N If yes, please describe _____

Was there any physical, sexual, or emotional abuse done to you or your siblings? Y N

If yes, please describe _____

Are you in any way fearful of your current partner? Y N Does your partner have angry outburst or temper tantrums? Y N

Has your partner ever pushed, grabbed, slapped, or hit you? Y N

Please list any specific medical conditions that you have _____

Are you taking prescription medications at this time? Y N If yes, please list: _____

How long have you been taking this? _____ Who prescribed it for you? _____

What is your daily or weekly alcohol intake? _____ Do you have a past or current history of drug abuse? Y Current Y Past N

If yes, please list _____

Have you been in therapy in the past? Y N If yes, when, for what, how long and with whom? _____

Was therapy helpful? _____

What is your reason for contacting Stenzel Clinical Services, and seeking therapy? What are your goals for therapy? _____

Is there anything else that you feel is important to this therapy process? _____

Please check any of the following that apply to you at present:

- Suicidal thoughts
- Weight gain
- Stomach trouble
- Constipation
- Chronic illness
- Excessive drinking
- Problems with parents
- Unable to have fun
- Feeling lonely
- Can't get going
- Feeling panicky
- Overly sensitive
- Easily excited
- Loss of meaning of life
- Loss/Disappointment
- Purposefully isolating
- Recent loss of someone close to me
- Always tired
- Fast heartbeat
- Bullied
- Muscles twitching
- Full of energy
- Excessive use of drugs
- Overly ambitious
- Feeling easily hurt
- Feeling inferior
- Feeling angry
- Can't make decisions
- Anxious inside
- Impatient with people
- Feelings of guilt
- Binging/Purging
- Loss of friendship
- Poor appetite
- Frequent sweating
- Feeling tense
- Nausea or Vomiting
- Financial problems
- Excessive spending
- Difficulties at school
- Lacking confidence
- No one understands me
- Don't like being alone
- Can't make friends
- Panic/anxiety attacks
- Very restless
- Unable to pray
- Restricting food intake
- Quick tempered/loss of temper
- Confused about personal religious practice
- Trouble sleeping
- Dizziness
- Cold feet and/or hands
- Headaches
- Marital problems
- Pornography use
- Feel like hurting someone
- Feeling grouchy
- Worried about health
- Always worried
- Unable to relax
- Sexual problems
- Feel like smashing things
- Unable to forgive
- Self-harm
- Loss of weight
- Shaky hands
- Diarrhea
- Fainting spells
- Difficulties at work
- Problems with children
- Crying spells
- Depressed
- Can't concentrate
- Nightmares
- Feeling fearful
- Fighting/quarreling often
- Shy with people
- Unable to be forgiven
- Not enjoying usual activities
- Other _____



Therapist: _____

Credit/Debit Card Authorization Form

Stenzel Clinical Services prefers that all patients have a credit card on file. This assists in the collection of payments due at the time of service and balances that accrue. Account numbers are kept secure. Charges and fees are described in the Benefits Inquiry and Informed Consent.

I authorize Stenzel Clinical Services to process payments on my credit/debit card for any and all balances that may accrue for sessions at Stenzel Clinical Services. This includes cost of sessions, co-pays, co-insurance, phone consultation and no show charges.

Client Name

DOB

Cardholder Name (Please print)

DOB

Card Number (16 digits)

Expiration Date (M/Y)

V Code (3 digits)

Type of card Visa Master Card Discover

Credit Card Billing Address:

City

Zip Code

Signature of cardholder/guarantor

Date