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

How were you referred to Stenzel Clinical Services? □ Insurance □ Physician □ School □ Church □ Friend □ Google
□ Other Please provide
Name:_________________________________Email__________________________________

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:___________________________

Addresss:____
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
				□	□	__________
				□	□	__________

Emergency Contact

Name	Relationship	Phone	Email			
				□	□	__________

Revised 10/19

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.

Our LPC and ALMFT therapists are supervised at Stenzel Clinical Services. If you have questions, please call our office. 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 resent 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_________________________

Signature (other family member in session) ___________________________________ 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

Family Members

Name	Relationship	Age/Deceased	Phone	Email

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

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

Date of your last physical:_____________ (M/Y)

Please list any specific medical conditions that you have ____

Are you taking prescription medications currently? □ Y □ N If yes, please list:____
How long have you been taking this? __________________ Who prescribed it for you?____

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?____
____

Reasons for Therapy

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

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

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

Revised 11.1.16