Symmetry Counseling

300 W. Adams, Suite 514
Chicago, Illinois 60606
Phone (312) 578-9990
Fax (312) 578-9004
www.symmetrycounseling.com

111. W. Washington St., Suite 1208
Chicago, Illinois 60602

NEW CLIENT REGISTRATION FORM

Client Information (Please Print Clearly)

Client #1	Client #2
Name_____	Name_____
Address_____	Address_____
City/State/Zip_____	_____
Date of Birth ___/____/_____	Date of Birth___/____/_____
Best Phone Contact _____	Best Phone Contact_____
Email Address_____	Email Address_____
Gender: □ Male □ Female	Gender: □ Male □ Female
Marital Status: □ Single □ Married □ Other	Marital Status: □ Single □ Married □ Other
Employment Status: □ Employed □ Student	Employment Status: □ Employed □ Student
Employer/School: _____	Employer/School: _____

Billing Information (Please Print Clearly)

Bill my insurance? □ Yes □ No If yes, please provide a copy of your insurance card to your clinician

PRIMARY INSURANCE
Insurance Company _____
Insured's Name _____
Insured's Employer _____
Insured's Identification #_____
Group Identification # _____
Insured's date of birth ___/___/_____
Insured's phone number_____
Insured's email contact_____
Client's relationship to insured: □ Self □ Spouse □ Child

Symmetry Counseling

CONSENT FOR TREATMENT

I/we, _____(and)_____, freely give my/our consent to take part in psychological treatment. The therapist has addressed my/our questions and/or concerns regarding confidentiality and the therapy process. With enough knowledge, and without being forced, I/we enter into treatment.

I/we understand that information about me/us may be disclosed without my/our consent if my/our therapist identifies that I/we am in immediate danger to myself or others, if there is suspicion of child and/or elder abuse or neglect, if a crime is committed on Symmetry Counseling's premises or against their personnel, or in order to protect national or international leaders and/or our national security.

I/we understand that no guarantees regarding the outcome of therapy can be given. This agreement shows this therapist's willingness to use and share his or her knowledge and skills in good faith. If it becomes clear that there is a need to transition care for any reason, I/we agree to discuss these concerns with my/our therapist and to participate in planning for transition if the issues cannot be resolved.

This agreement also shows my/our commitment to pay for services. I/we agree to pay the full disclosed amount per session and to pay at each session. I/we understand and accept that I/we am fully responsible for this fee, but that my/our therapist will help me/us in obtaining payment from any insurance coverage I/we have. I/we also understand that in order to bill a third party (insurance), confidential information such as my diagnosis, treatment goals, and treatment progress may have to be released to the third party.

My signature below means that I understand and agree with the points above.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

I have discussed the issues above with this client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Clinician: _____ Date: _____

Symmetry Counseling

INSURANCE FINANCIAL CONSENT & CLIENT RESPONSIBILITIES

As a client, you are responsible for knowing the provisions of your health insurance plan, including which mental health professionals are in your network as well as which services need pre-certification prior to services. You are responsible for contacting your insurance company and understanding your benefits, although this does not guarantee coverage. Your health insurance policies and coverage determinations may vary from year to year, and allowed or contracted rates may vary between health insurance policies and for various services. Per your agreement with your insurance company, you are responsible for your co-payments at the time of service as well as your payment for care provided or coordinated, including paying for your deductible.

Your insurance provider may request the following information for the purpose of obtaining reimbursement for services. This information includes admitting diagnosis, final diagnosis, discharge summary, and designated clinical records (e.g., treatment plans, progress notes, test results, etc.). This information may be released to any or all of the following entities as needed. I authorize Symmetry Counseling, LLC to release any information to third party payers responsible for service payments, including review agents/auditors and managed care agents. The agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that if my clinician is in my network, the clinician has agreed to the customary rate contracted by the insurance company. I understand that my insurance company reserves the right to refuse payment for services. I understand that in such a case, I have the right to appeal to my insurance company for payment. **I understand that I am responsible for services provided which are not covered by my insurance company.**

I understand that in some cases I and/or my dependents may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize **Symmetry Counseling, LLC** to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I certify that I am the client and that I have read and comprehend this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms. I understand that my co-pay or co-insurance is _____. I understand that this fee is due at the time of service.

Signature of Client or Legal Representative: _____ Date: _____

Signature of Client or Legal Representative: _____ Date: _____

Signature of Clinician: _____ Date: _____

Symmetry Counseling

SELF-PAY FINANCIAL CONSENT & CLIENT RESPONSIBILITIES

For clients not using health insurance, our self-pay fees are as follows:

Masters level clinician

Individual therapy:	45-minute session	$130/session
	55-minute session	$140/session
Couple/Family therapy:	45-minute session	$150/session
	55-minute session	$160/session

Doctoral level clinician

Individual therapy:	45-minute session	$150/session
	55-minute session	$175/session
Couple therapy:	55-minute session	$165/session

Individual 30-minute session $50.00

Additional Services

Prenuptial /Premarital mediation: $225/session

These rates may change periodically, and you will be informed prior to any rate change.

I understand that my self-pay session fee is _____. I understand that this fee is due at the time of service. I understand that these rates may increase periodically and that I will be informed prior to any rate change.

Signature of Client or Legal Representative: _____ Date: _____

Signature of Client or Legal Representative: _____ Date: _____

Signature of Clinician: _____Date: _____

Symmetry Counseling

Financial Policy

I hereby acknowledge that I am personally liable for all fees for services performed on my behalf by Symmetry Counseling LLC ("Symmetry"). These fees include full session charges for those without insurance; co-pays for those with co-pay insurance plans; and all unreimbursed insurance claims, including amounts that fall within client's deductible.

While Symmetry will submit claims on my behalf to health insurance companies whose plans Symmetry accepts, I am fully liable for such charges that are not paid in a timely manner by the insurance company. I irrevocably agree that any bill that remains unpaid 30 days after we mail/email it to the responsible party, will be charged to my credit card.

If you are unable to keep an appointment, our office requires 24 hours as an acceptable notification of cancellations, without a fee assessment. This courtesy on your part will make it possible to give your appointment to another client who needs it. In the even that you are unable to give us such notice, you will incur a no show or late cancellation fee of $75.00

I hereby authorize the credit card company listed below to recognize and approve charges against the credit card listed below as submitted by Symmetry. I certify that the below listed card is issued to me, and/or that I am an authorized signatory on the account; and that said card is currently valid. I further agree to maintain and keep on file with Symmetry a valid credit card at all times.

Client Name: _____

Billing Address: _____

Billing City, State, and Zip Code: _____

Credit Card Type: ☐ Master Card ☐ Visa ☐ Discover

Symmetry Counseling does not accept American Express

Credit Card Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3-digit CVV Code (located on the back of credit card): _____ _____ _____

Expiration Date: _____ / _____

Cardholder Signature _____

I have read, understand and agree to this policy. (Parent or guardian complete if patient is a minor.)

_____	_____	_____
Print Name	Signature	Date

Symmetry Counseling

Notice of Privacy Practices-Brief Version

RECEIPT OF NOTICE OF PRIVACY PRACTICIES AND CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION Effective date March 1st, 2017.

I have received, understand and consent to this practice's Notice of Privacy Practices as written. The notice of privacy detailed information about how the practice may use and disclose my confidential information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices. If changes to the policy do occur, this practice will provide me revised Notice of Privacy Practices upon my request.

I ACKNOWELDGE AND AGREE THAT NO AMENDEMENT TO THIS FORM IS PERMITTED. I MAY REQUEST AMENDEMENTS TO MY MEDICAL RECORDS IN ACCORDANCE WITH STATE AND FEDERAL LAW AND REGULATION.

With this consent, **Symmetry Counseling, LLC** or our agents may:

__ communicate with me about billing and scheduling via **email.** I understand that Symmetry Counseling cannot guarantee the security of email communication especially related to treatment information. I further understand that my Personal Health Information (PHI) may be at risk if I chose to communicate with my therapist via email about treatment and I assume sole responsibility and liability for this risk.

__ leave a message on client's/family **voicemail** confirming your appointment and/or to provide information you requested regarding your treatment.

__ **not** communicate with me via **email.**

__ **not** leave a message on client's/family **voicemail.**

I have received, read, and understand the Notice of Privacy Practices attached to this document.

Signature of Client: _____ Date: _____

Parent/Guardian: _____ Date: _____
(Please specify relationship to client)

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION TO PHYSICIANS

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111. W. Washington St. 2108
Chicago, IL 60602

I, _____,authorize Symmetry Counseling, LLC to send notice of my treatment to the following physicians (please list below). The purpose of communicating with your other healthcare professionals is to collaborate and provide the most effective care through shared insight and treatment goals.

Communication will be initiated at the beginning of treatment (__/__/____) or upon completion of this form, and continue until therapy is terminated. The client consents to share the following information:

___ Dates of treatment
___ Diagnosis
___ Goals of therapy
___ Outcome of treatment

_____

Name Physician Specialty

_____

Address City State Zip

_____

Phone Email

_____

Name Physician Specialty

_____

Address City State Zip

_____

Phone Email

Signature of Client _____Date_____

Signature of Parent/Guardian _____Date_____

Symmetry Counseling

NOTICE OF PRIVACY PRACTICES

We respect our clients' confidentiality and only release information about you in accordance with state and federal laws. THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. Use and disclosure of protected health information

We use and disclose the minimum necessary health information about you for your treatment, for payment for your services, and for Symmetry Counseling's health care operations per federal and state laws.

a. For treatment. We use and disclose your health information internally in the course of your treatment at Symmetry Counseling.

b. For payment. We may use and disclose your health information to arrange and obtain payment for your services.

c. For health care operations. We may use and disclose your health information within Symmetry Counseling as a part of our internal health care operations.

d. We require your written permission in order to share your personal health information for marketing and/or sale of client information.

e. We will not use or disclose your psychotherapy notes without your prior written authorization except for the following: 1) use by the originator of the notes for your treatment, 2) for training our staff, students, or other trainees, 3) to defend ourselves if you sue us or bring some other legal proceeding, 4) if the law requires us to disclose the information to you or the Secretary of HHS or for some other reason, 5) in response to health oversight activities concerning your therapist, 6) to avert a serious and imminent threat to health or safety, or 7) to the coroner or medical examiner after you die. To the extent that you revoke an authorization to use or disclose your psychotherapy notes, we will stop using or disclosing these notes.

2. Information disclosed without your consent

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

a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.

b. Judicial and Administrative proceedings. We may disclose your personal health information in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for Workers Compensation.

c. Public Health Activities. If we felt, you were an immediate danger to yourself or others, we may disclose health information about you to the authorities, as well as alert any other person who may be in danger.

d. Child/Elder Abuse. We may disclose health information about you related to the suspicion of child and/or elder abuse or neglect.

e. Criminal Activity or Danger to Others. We may disclose health information if a crime is committed on our premises or against our personnel, or if we believe there is someone who is in immediate danger.

f. National Security, Intelligence Activities, and Protective Services to the President and Others. We may release health information about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.

g. Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting organizations may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.
h. Scheduling Appointments. Symmetry Counseling may use your phone number to call you and leave messages to schedule or remind you of appointments.

3. Your rights regarding your health information
a. Right to Inspect and Copy. You have the right to look at or get copies of your health information, with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred. You also have the right to request and obtain an electronic copy of your personal health billing records. We will provide you with a copy or summary of your electronic billing records within 30 days of your request.
b. Right to Amend. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We have the right to deny your request under certain circumstances, and we will tell you why in writing within 60 days.
c. Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we have disclosed your health information for a purpose other than treatment, payment, or health care operations. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Such accountings are available for disclosures beginning April 14, 2003 and remain available for six years after the last date of services at Symmetry Counseling.
d. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you. For example, you have the right to restrict certain disclosures of your personal health information to a health plan (e.g., insurance company) when you pay out-of-pocket in full for healthcare services. To request a restriction after therapy is completed, you must make your written request to the Privacy Officer.
e. Right to Request Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you may ask that we contact you only by mail or at work. You must make this request in writing and it must specify the alternative means or location that you would like us to use to provide you information about your health care. We will make every attempt to accommodate reasonable requests.
f. Right to Obtain Paper Copy of this Notice. You have the right to obtain a paper copy of this notice and any amended notice upon request. Copies will be available in each of our waiting rooms at Symmetry Counseling. You may also obtain a copy of this notice at our website, www.symmetrycounseling.com.
g. Right to Notification of a Breach of Confidentiality. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We reserve the right to change our privacy practices provided such changes are permitted by applicable law.

Questions or Complaints
You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer listed above and with the Secretary of the Department of Health and Human Services by sending a letter to 200 Independence Avenue, SW, Washington, DC 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.