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Assignment of Insurance Benefits

Mental health benefits are reimbursed differently than general medical benefits, thus it is important that you verify your health plan prior to your initial appointment. Please contact your insurance provider to address questions directly.

I hereby authorize Illuminate Therapy & Wellness, LLC to release the necessary information to file any insurance claims on this account. I hereby authorize all benefits payable directly to Illuminate Therapy & Wellness, LLC. I understand that I am financially responsible for all the charges incurred for services rendered to me and I hereby agree to pay all charges regardless of insurance coverage. Payment is expected at the end of each session.

Name of Client:

Name of Insured (if different from Client):

Insured Date of Birth:

Relationship: ☐ Self ☐ Spouse ☐ Dependent

Insurance Provider:

Member ID:

Group Number:

Your signature is necessary in order for Illuminate Therapy & Wellness, LLC to submit your claims to your insurance provider. I authorize the use of this signature on all insurance submissions. I authorize the release and use of information required to collect outstanding charges on this account. I have read this information and agree.

Client Signature. Date:

(Client if 12 years or older)

Parent/Guardian Signature Date:

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature Date:

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Coordination of Care for Primary Care Physician and Health Information

Pursuant to Illinois Law and in order to provide you with the highest quality of care, we wish to inform you that it is desirable that you confer with your primary care physician (PCP), if you have one, about seeking and receiving mental health treatment at Illuminate Therapy & Wellness, LLC. If you have a PCP, it is required that your therapist share pertinent information regarding a mutual patient's prognosis and treatment, unless you waive such notification. We request that you complete this form if you wish to authorize your therapist to exchange information regarding your care at Illuminate Therapy & Wellness with your PCP. If signed, this authorization will remain in effect for one (1) year from the date signed.

Please choose one of the following:

_____ I do give permission to notify my PCP.

I agree to you notifying my PCP that I am receiving mental health treatment services. I agree to signing the attached Release of Information (ROI) form permitting you to communicate with my PCP.

Name of PCP:

Address:

Telephone:

_____ I do *not* give permission to notify my PCP.

I waive notification of my PCP that I am receiving mental health services, and I direct you not to notify him/her.

_____ I do not have a PCP and do not wish to confer with one.

Client Signature Date:

(Client if 12 years or older)

Parent/Guardian Signature Date:

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature Date:

HEALTH AND MEDICAL INFORMATION

Date of your last physical exam (Month/Year):

What is your current health status? Please note any pertinent history you believe is important for your therapist to know.

Psychiatrist (if applicable):	**Telephone:**
Please list medical problems:	
Type:	**Date of Diagnosis:**

Please list *all* current medications and/or supplements (include birth control, OTC medication, herbal remedies, vitamins).

Medications:	**Dose:**

FAMILY HISTORY

Check all that apply and list the family member.

Condition	**Family Member:**
☐ Attention-Deficit/Hyperactivity/Impulsivity (ADD/ADHD)	
☐ Addiction (Specify):	
☐ Autism Spectrum Disorder/Asperger's Disorder	
☐ Bipolar Disorder	
☐ Depression	
☐ Eating Disorders	
☐ Generalized Anxiety and/or Phobias	
☐ Learning Problems/Disabilities/Dyslexia/Speech	
☐ Obsessive-Compulsive Disorder (OCD)	
☐ Schizophrenia/Psychosis	
☐ Seizures/Other Neurological Disorder	
☐ Sleep Disorder	
☐ Other:	

NUTRITION SCREEN

Please give as much detail as you can for either yourself, or whom you are completing this form for.

1. Has there been any recent change in your appetite? ☐ Yes ☐ No

2. What is your Height: _____ Current Weight: _____ Average Weight: _____

3. Have you gained or lost weight in the past year? ☐ Yes ☐ No
   If so, how much? Gained _____ pounds *OR* Lost _____pounds

4. Please describe your diet: _____

4. Do you omit any foods because of health reasons? ☐ Yes ☐ No
If yes, what are they? _____

5. Do you omit any foods because of religious reasons? ☐ Yes ☐ No
If yes, what are they? _____

6. Do you include any food because of health benefits? ☐ Yes ☐ No
If yes, what are they? _____

7. Do you have difficulty with: ☐ Swallowing ☐ Chewing ☐ Diarrhea ☐ Constipation ☐ Vomiting ☐ Indigestion ☐ Heartburn

8. Do you use any purging methods: ☐ Laxatives ☐ Diuretics ☐ Diet Pills ☐ Vomiting

9. What type of exercise do you do and how often? _____

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Credit Card on File Policy

Thank you for choosing Illuminate Therapy & Wellness for your behavioral health needs. We are committed to providing you with exceptional care, as well as making our insurance billing processes as simple and efficient as possible. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This is driving many practices to adopt new financial policies to enable more efficient operational processes. Some insurance plans require deductibles and co-payments in amounts not known to you or us at the time of your visit.

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, we require all patients keep an active credit card on file with us through our secure practice software. We will bill your insurance company first and upon their determination of benefits, we will only charge your credit card when they inform us of patient responsibility. Circumstances when your card would be charged include but are not limited to: missed or canceled sessions without 24 hour notice, missed co-payments, deductible and co-insurance, any non-covered services and/or denial of services and the balance of charges not paid by my insurance company 60 days after the end of treatment.

- Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.

- When we receive the EOB, we will enter all pertinent payment information into our system. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be sent to you.

If the credit card we have on file for you changes, please notify your clinician IMMEDIATELY by phone or email. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. If we run your credit card and it is denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

We will contact you or leave you a phone message on the phone number you provided for us, asking you to give us a call with the new number right away. We will enter the new credit card number into your file, and that will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you began treatment.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the

same card in a timely manner. You are welcome to leave an HSA (Health Savings Account) or Flex Plan Card on File for payment of services, but we cannot use this card to charge for missed or late cancelled appointments. You may also pay for the visit with cash or a personal check.

Credit Card on File Policy Acceptance Form

By signing below, I agree to all of Illuminate Therapy & Wellness's Credit Card on File Policy and I authorize Illuminate Therapy & Wellness to keep my signature and a valid credit/debit card number securely on-file in my account.

I allow Illuminate Therapy & Wellness to automatically charge my credit card for any outstanding balances. These may include insurance denials for ANY reason (including no referral on file); missed or canceled appointments; deductibles; co-insurances; partially paid claims, or balances owed 60 days following termination of treatment. Missed or canceled appointments without 24-hour notice will be charged the missed appointment fee of $125.00 at the time of the appointment.

If the credit card that I give today changes, expires, or is denied for any reason, then I agree to immediately give Illuminate Therapy & Wellness a new, valid credit card, which I will allow them to key-in over the phone. Even though Illuminate Therapy & Wellness is not swiping this card in person, I agree that the new card will still be subject to the financial policy listed here and may be used with the same authorization as the original card which I presented in person.

I understand that I am responsible for payment for all mental health services provided to me by Illuminate Therapy & Wellness. I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow Illuminate Therapy & Wellness to immediately charge my credit card on file for the balance if that happens. I understand that this form is valid until I cancel this authorization through written notice to Illuminate Therapy & Wellness.

Credit Card Information:

☐Visa ☐MasterCard ☐Discover

Account Number: _____ Expiration Date: _____

Cardholder Name: _____Security Code (CVV): _____

Client Name: _____ Relationship to Client: _____

Billing Address: _____
Street City Zip

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form. I understand this form is valid unless I cancel the authorization through written notice to Illuminate Therapy & Wellness.

Signature _____ Date _____

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Eye Movement Desensitization and Reprocessing (EMDR) Informed Consent

Eye Movement Desensitization & Reprocessing (EMDR) is a form of therapy that utilizes bilateral stimulation (BLS) usually in the form of eye movements or tapping in order to accelerate the brain's capacity to process and heal a troubling memory, thought, feeling, or phobia. BLS stimulates the same eye movements which occur during Rapid Eye Movement (REM) or dream sleep. Some clients can experience relief or positive effects in just a few sessions and others require additional treatments. EMDR is effective in treating trauma-related symptoms, whether the traumatic event occurred many years ago or yesterday.

Research has demonstrated that EMDR is effective for the treatment of Post-Traumatic Stress Disorder (PTSD), phobias, panic attacks, anxiety disorders, stress, sexual and physical abuse, disturbing memories, complicated grief and chronic pain.

The possible benefits of EMDR treatment include the following:

1. The memory or event is remembered, but the painful emotions and physical sensations,

   disturbing images and thoughts are no longer present.

2. EMDR helps the brain reintegrate the memory or event and store it in a more appropriate place in the

   brain. The client's own brain reintegrates the memory or event and does the healing.

The possible risks of EMDR treatment include the following:

1. Reprocessing a memory or event may bring up associated memories. This is normal and these memories will also be reprocessed.
2. During the EMDR, you may experience physical sensations and retrieve images, emotions, and sounds associated with the memory or event.
3. Reprocessing of the memory or event normally continues after the end of the formal therapy session. Other memories, flashbacks, feelings, and sensations may occur, and you may have dreams associated with the memory. Frequently, the brain is able to process these additional memories without help, but arrangements for assistance will be made in a timely manner if the client is unable to cope.

As with any other therapeutic approach, reprocessing traumatic memories can be uncomfortable. This means that some individuals will have difficulty tolerating EMDR treatment well and/or may need additional preparation before processing traumatic events using EMDR.

1. There is no known adverse effect for interrupting EMDR therapy; therefore, you can discontinue treatment at any time.
2. Alternative therapeutic approaches may include individual or group therapy, medication, or a different psychotherapy modality on an individual basis.

The client must:

1. Be able to tolerate high levels of emotional disturbance, have the ability to reprocess

   associated memories resulting from EMDR therapy, and to use self-control and relaxation techniques

   such as calm place, container, belly breathing, etc.

2. Disclose to me and consult with your physician before starting EMDR therapy if you have a history of

   current eye problems, a diagnosed heart disease, elevated blood pressure, or are at risk for or have a history of stroke, heart attack, seizure or other limiting medical conditions that may put you at medical risk. Pregnant women should consult with their physician. Due to the stress related to reprocessing some traumatic events, postponing may be appropriate in some cases.

3. Inform me if you wear contact lenses and remove them if they impede eye movements due to irritation or eye dryness. I will discontinue BLS if you report eye pain.
4. Before participating in EMDR, discuss with me all aspects of an upcoming legal court case where testimony is required. You may need to postpone EMDR treatment if you are the victim or witness to a

crime that is being prosecuted because the traumatic material processed using EMDR may fade, blur or

disappear and your testimony may be challenged.

5. Consult with your medical doctor before utilizing medication. Some medications may reduce the

   effectiveness of EMDR. For example, benzodiazepines may reduce effectiveness possibly due to state-

   dependent processing and/or regression may occur after ceasing antidepressants.

6. EMDR is contraindicated with recent crack cocaine users and long-term amphetamine users.
7. Discuss with me any dissociative disorders with little treatment progress. EMDR may trigger these

   symptoms but may also be helpful in attempting to resolve them.

I HAVE READ AND UNDERSTAND THE POSSIBLE OUTCOMES OF EMDR LISTED ABOVE AND UNDERSTAND THAT I CAN END EMDR THERAPY AT ANYTIME. I AGREE TO PARTICIPATE IN EMDR THERAPY AND I ASSUME ANY RISKS IMVOLVED IN SUCH PARTICIPATION.

Name _____

Signature _____ Date _____

Signature of Therapist _____ Date _____

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Your responses to the questions on this form are strictly confidential and will become part of your medical record.

PERSONAL INFORMATION

Name (Last, First, MI):				**Date of Birth:**	
Gender: ☐F ☐M ☐T ☐Other(Specify):				**Preferred Gender Pronoun/s:**	
Address:					
City, State, Zip:					
Home Phone:	**Cell Phone:**		**Email:**		
Preferred method of confidential communication: ☐ Home			☐ Cell		
☐ Email					
Appointment Reminders: Illuminate Therapy & Wellness (IT&W) offers appointment reminders via text message or email. I consent for IT&W to send appointment reminders using: ☐Text /Cell Phone: ☐Email: **I would like to receive email updates from ITW:** ☐Yes ☐No					
Marital Status:	☐Single	☐Married	☐Partner	☐Separated	☐Divorced ☐Widow
Living with:	☐Alone	☐Spouse	☐Partner	☐Roommate	☐Parents ☐Other:
Employment:	☐Full Time	☐Part Time	☐Unemployed	☐Other:	
Student:	☐Full Time	☐Part Time	Grade: _____		
Education:	☐High School	☐GED	☐2 Year College	☐4 Year College	☐Graduate School ☐Other:
Is there a racial and/or ethnic group you identify with that you would like your therapist to be aware of? If so, please list here:					
How did you hear about ITW?					
☐Family/Friend ☐Insurance ☐Physician/Psychiatrist/Hospital Staff ☐School ☐Web Search ☐Other Please provide their name and contact information:_____					
Emergency Contact: Name:		Relationship:		Phone:	
Others you wish to have access to scheduling appointments and/or billing information:					
Name & Relationship:				Phone:	
Name & Relationship:				Phone:	

RESPONSIBLE PARTY

Complete if the Client is a minor OR if someone other than the Client is responsible for payment.

Name (Last, First, MI):			**Date of Birth:**	
Address:				
City, State, Zip:				
Home Phone:	**Cell Phone:**	**Email:**		
Preferred method of confidential communication: ☐Home Phone:		☐Cell Phone:		
☐Email:				
Relationship to Client: ☐Mother	☐Father	☐Legal Guardian	☐Spouse	☐Other (Specify):

Have you been hospitalized and/or received treatment for a psychiatric illness? ☐Yes (Specify):			☐No
Approximate Date(s)	Length of Stay	Hospital/Center	Reason for Admission
Have you ever had suicidal thoughts and/or attempts? If yes, please list the occurrences below:			
Approximate Date(s):			

How did you attempt (method(s)?

PREVIOUS TREATMENT

Have you been to therapy previously? ☐Yes ☐No
If yes, please list approximate dates, reason(s) for seeking treatment, and reason(s) treatment ended:

DESCRIBE YOUR REASON(S) FOR SEEKING THERAPY:

What are your therapeutic goals?
Are you interested in group therapy? ☐Yes ☐No If yes, what kind?
Are you required by a court of law to attend therapy as part of a legal proceeding? ☐Yes ☐No
Other pertinent information you would like your therapist to know:

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Financial Policy and Agreement

Thank you for choosing Illuminate Therapy & Wellness, LLC (IT&W) as your mental health counseling provider. We are committed to providing you with the best care possible. Please read the following information carefully and completely. Should you have any questions, please discuss with your therapist. Your clear understanding of our Financial Policy and Agreement is important to our professional relationship. **You must sign and date the form prior to beginning your treatment.**

INSURANCE

Insurance coverage is a contract between the patient and the insurance carrier. You are responsible for all co-payments, deductibles and payments for non-covered services, which are due at the time of treatment. We accept MasterCard, Visa and Discover, HSA/FSA debit and credit cards, as well as cash or check. Although we do our best to verify your eligibility for mental health services, IT&W is not responsible for denied claims and verification of insurance benefits is an estimate, not a guarantee of benefits. It is the responsibility of the patient to know and understand the benefits of his/her particular insurance. You are advised to seek assistance in understanding your mental health benefits by contacting the Human Resources Department with your employer or by calling the "Member Services" number on the back of your card. In the event that a claim is denied, you are personally responsible for the full invoice amount.

There are numerous insurance networks, yet our clinicians are not a part of all these networks, and, therefore, we have not agreed to accept a reduced fee from all insurance companies. Many insurance companies pay a different percentage of charges based on whether or not the clinician is a part of their network. If you choose to see one of our clinicians who is out-of-network with your insurance carrier, you are responsible for the out-of-network benefits assigned for the type of service being billed.

Claims will be submitted to your primary insurance company on your behalf for services rendered. We are unable to directly bill secondary insurers. Billing any other secondary insurance must be done by the patient. The balance due on your account after receipt of payments from primary insurers must be paid in full by you. We will provide you with the documentation necessary for you to file your secondary insurance claim. Changes in your insurance company or insurance coverage (such as annual renewal, expiration or type of coverage provided) may affect your financial responsibility. Please notify your therapist if you change your insurance plan or anticipate a change in your coverage.

Client Initials: _____ Therapist Initials: _____

If you prefer to file your insurance on your own, we will be happy to provide you with a "superbill" to assist you if you file your own insurance claims.

FEES AND PAYMENT

Payment is expected at the time of service. Should you be enrolled in a PPO or managed health care plan, we require that you make your co-payment (including deductibles and/or any co-insurance amount) at the time of each visit. If you are not using insurance, you will be responsible for the full fee for the service provided.

Credit Card on File

You are required to provide credit card information and authorization for your therapist to charge your card automatically in the case of missed appointments or late cancellations (less than 24 hours prior to scheduled appointments). A receipt for each payment is available upon request.
Your credit card will be saved on file through our secure practice software. You will have the option at the time of your session to pay co-payments/deductibles via your credit card on file as well. Please inform your therapist if you do not want your credit card on file to be processed in this manner. The credit card on file will also be billed directly for all balances owed (including insurance payment beyond the 60 days mandated by Illinois law).

Returned Checks

In the event that a deposited check is returned due to insufficient funds, a $50.00 fee will be charged. In addition, you will be responsible for the original amount owed. If such situations arise, you may be asked to pay either with a credit card or cash for subsequent sessions.

Missed Appointments

Your appointment is reserved exclusively for you. If you miss your appointment or cancel with less than 24 hours notice, your therapist is unable to care for another client. Thus, missed appointments, or those cancelled with less than 24 hours of your scheduled appointment time are subject to a missed appointment fee of $125.00.

Non-Covered Services

We regard mental health care as collaboration between patient, therapist and other members of your treatment team; including but not limited to psychiatrists, school personnel, primary care physicians, etc. At times, phone consultation, reading or writing documents, formal assessments, report writing, attendance at school staffings, etc. may be requested to ensure cohesive and quality treatment is being established on the client's behalf. You are fully responsible for payment for the time required by your therapist to complete any non-counseling services, which will be billed to you at the following rates:

Phone Calls: There may be times when you need to speak with your counselor over the phone. These phone calls are not meant to take the place of a face-to-face session in our office, but may be related to a question or advice. No charges will be assessed for routine phone calls for appointments and routine clinical consultation lasting less than 15 minutes. Charges for calls lasting longer than 15 minutes will be assessed at a rate of $37.50/15-minute increments, or $150.00/hour. Please be advised that insurance companies do not reimburse for crisis phone calls.

Client Initials: _____ Therapist Initials: _____

Written Work: If you request any letters, forms, or any other paperwork to be completed please allow a minimum of 1 weeks' notice and the fee structure is as follows - $150.00 per hour; prorated based on time spent at 15-minute increments of $37.50 each. Please note that requests to complete FMLA or disability paperwork requires at least 6 weeks advance notice to properly assess whether we can support your need.

Record Copying: The office will charge a minimum $25.00 copying fee for the copying of medical records up to 50 pages. After 50 pages, the rate will be $0.25 per page and $25.00 per hour. Postage/delivery costs will also be applied.

Out of Office Activities: If therapists are asked to attend meetings outside the office (school staffing, or observations, etc.) the billable time is $175.00/hour and for travel to/from any such event is billed at 50%: $87.50/hour, which can be prorated.

Legal/Court related Matters: We do not provide therapy for the explicit purpose of providing records or evidence for legal matters. Our purpose is to support our clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing to not involve us in legal/court proceedings. If you do become involved in legal proceedings that require our participation, fees for our professional time are billed at $200.00/hour, including preparation time, with travel time being billed at 50%: $100.00/hour.

Responsible Party

If the patient is a minor (or is subject to guardianship under Court Order), a parent or guardian must:

1. Consent to treatment
2. Accept responsibility for payment for our services
3. In the case of divorced or separated parents, other arrangements (including Court Orders and Decrees) notwithstanding, the parent or guardian signing this form will be the party billed and agrees to be personally liable for any and all co-payments and other balances outstanding.

Billable Party Name: _____ **Phone:** _____

Relationship to Client: _____

Address: _____

Street City State Zip

Thank you for taking the time to read through our Financial Policy and Agreement. If you have any questions, please do not hesitate to ask us, we are here to help you. Please sign and date this page indicating that you have read and understand this policy and agree to abide by it.

Client Initials: _____ Therapist Initials: _____

I have read, understand, and agree to the Financial Policy and Agreement of Illuminate Therapy & Wellness provided in this document and authorize IT&W to send correspondence relating to dates of service and charges to the billable party stated above.

Client Signature

_____Date_____

(Client or Parent/Guardian if Minor/Personal Representative; 12 years or older)

Partner/Spouse or Parent/Guardian Signature

_____ Date_____

(If Applicable)

Witness Signature:

_____ Date: _____

Acknowledgement-Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received the Notice of Privacy Practices from Illuminate Therapy & Wellness. I am also aware that a Notice of Privacy Practices is obtainable by going to www.illuminatingyou.com and clicking on the “Client Forms” tab. Forms are also available on location.

Client Signature

_____Date_____

(Client or Parent/Guardian if Minor/Personal Representative)

Partner/Spouse or Parent/Guardian Signature

_____Date_____

(If Applicable)

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NOTICE OF PRIVACY PRACTICES

Welcome to Illuminate Therapy & Wellness. This notice contains important information about our professional services and business policies. We would like you to have a clear understanding of the services we provide and our expectations of you, our client. If you have any questions or need further clarification, please consult your therapist. Upon signing, this document represents an agreement between us. Please review this section carefully.
At Illuminate Therapy & Wellness (IT&W), we understand that in order for clients to feel comfortable discussing private and revealing information, they need to see their therapist's office as a safe place where they can freely share anything they would like, without fear of that information leaving the room. There are laws in place to protect your privacy, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA):a federal law that sets national standards for patient rights with regards to protected health information (PHI). As psychotherapists, we are committed to treating and using your PHI responsibly. This Notice describes the procedures we use to protect your information and the circumstances under which your PHI may be disclosed. The rules for confidentiality of mental health records are recorded in the Illinois Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110) and in the privacy rules of the Health Insurance Portability and Accountability Act of 1996.

Uses and Disclosures of Healthcare Information for the Purpose of Providing Services
Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to responsibly use and disclose your healthcare information for these purposes.

INFORMATION DISCLOSED WITHOUT YOUR CONSENT

This notice describes policies related to the use of your medical records and your rights as a client seeking therapeutic services. We are committed to maintaining our clients' confidentiality, and we will only release information in accordance with federal and state laws and ethics of the counseling profession. Information that you share in treatment is held in the strictest confidence possible under law. Under Illinois and federal law, information cannot be divulged to any outside parties without your written and verbal consent except for the following:

- Information that you pose a "clear and imminent" danger to yourself, others are posing "clear and imminent" danger to you or when a therapist believes a clear and immediate danger exists to one or more persons.
- Information that would assist others treating you for a medical emergency.
- Information of awareness of any real or alleged abuse to children, elderly, or disabled individuals. We are mandated reporters in the State of Illinois and are obligated to report this type of information to the Department of Children and Family Services (DCFS).
- Information necessary for your insurance company to process your claim(s).
- General information about treatment of minor children, may, in some cases, be disclosed to their parents.

- Required by Law: IT&W may use and disclose your health information in response to court or administrative order, if you are involved in a lawsuit or similar proceedings. We may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

INFORMATION DISCLOSED WITH YOUR CONSENT

In general, we may need to use client information to review treatment procedures, coordinate your care and conduct business activities. Information may be used for certification, compliance and licensing.

Marketing Health-Related Services: IT&W will not use your health information for marketing communications without your written authorization.

Payment: Information will be used to obtain payment for the treatment of services provided. This will include contacting your health insurance for prior approval of planned treatment and/or billing purposes. Insurance companies will ask for this information to verify that services were provided and/or to decide whether to continue paying for treatment. Like us, insurance companies are also bound by HIPAA laws and must keep your information confidential.

Treatment: Treatment information about you may be disclosed to provide, manage and coordinate your care. This includes sharing information with others who are being consulted or to whom you are being referred.

Will my employer know I saw a psychotherapist if I use my company's insurance?

Employers do not receive information about the health service an employee receives, even if he/she uses company insurance.

What information can I share about my psychotherapy treatment?

Privacy is your right as a client, and it is up to you how much information you share with others. We are ethically and legally bound to protect your privacy regardless of what information you choose to share with others.

Changes to the Terms of this Policy

ITW reserves the right to change the terms of its Privacy Policy and to make the new Policy provisions based on the needs of the practice and changes in state and federal law. You will be notified of any changes in the Policy. This notice is effective as of September 1, 2020 and applies to all persons who procure service from a provider at IT&W.

I _____, have read, fully understand and accept IT&W's Notice of Privacy Practices.

Client Signature Date:

(Client if 12 years or older)

Parent/Guardian Signature Date:

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature Date:

Illuminate Therapy & Wellness Social Media Policy

Illuminate Therapy & Wellness (IT&W) protects your privacy in accordance with the ethical standards of our profession and HIPAA compliance laws.

- IT&W therapists are not allowed to engage with clients on social media because this potentially compromises a client's right to privacy.

- Texting between client and therapist or vice versa is not HIPAA compliant and is prohibited.
- Information that is emailed may become a matter of clinical record. We will do everything within our means to protect such information, however we cannot guarantee it. Please keep email contents basic and do not include personally sensitive information.
- An emergency might prompt you to call your therapist through our emergency line. If your therapist is unable to respond, you'll be connected to our on-call therapist. Texting or emailing are inappropriate methods of communication to address a life-threatening emergency. If this is the case, please call 911.

I _____, have read, fully understand and accept IT&W's Social Media Policy.

Client Signature Date:

(Client if 12 years or older)

Parent/Guardian Signature Date:

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature Date:

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Authorization to Release/Exchange Information

All information exchanged during the course of our work together will be held in the strictest confidence. Illuminate Therapy & Wellness (IT&W) will not release confidential information to anyone without your specific authorization, unless the law requires disclosure. This authorization form specifies with whom verbal and written information about you may be exchanged, the nature of the information, and the purpose for which it is to be exchanged.

I, _____, hereby authorize _____ Of Illuminate Therapy & Wellness located at Palatine, IL 60067, Phone: 847- fax: 847 to:

[ ] Disclose information to [ ] Receive information from [ ] Exchange information with
Name(s): _____ **Phone #**: _____
Agency/Company Name: _____
Address: _____

Street City State Zip

Regarding: _____ Date of Birth: _____ (Client Name – please print)

The information to be disclosed is:

- [ ] Treatment Summary [ ] Attendance Information [ ] Psychiatric Diagnosis
- [ ] Treatment Plan [ ] Treatment Recommendations
- [ ] Other (specify) _____

The specific purpose and limitations of the types of information to be released are as follows:

(Check all that apply)

[ ] Treatment Coordination [ ] Treatment Planning [ ] Case Collaboration

This consent is effective on _____ and shall remain valid until: _____
I, the undersigned, understand that this information may be protected by Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) plus applicable state laws. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time and such revocation must be in writing and received by my provider to be effective. Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form.

Client Signature _____Date_____
(Client or Parent/Guardian if Minor/Personal Representative; 12 years or older)

Partner/Spouse or Parent/Guardian Signature _____Date_____
(If Applicable)

Witness Signature: _____ Date: _____

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RIGHTS AND RESPONSIBILITIES

Psychotherapy is a unique and cooperative relationship between you, the client, and your therapist. Each member in this relationship has certain responsibilities: the therapist will provide knowledge, expertise, and clinical skills and the client will be expected to bring an attitude of collaboration and commitment to the therapeutic process. Therapy usually leads to healthier relationships, solutions to problems and significant reductions in feelings of distress, but there are no guarantees regarding the outcome. We encourage you to be open and to communicate with your therapist should doubts and/or concerns arise during your treatment.

Illuminate Therapy & Wellness, LLC (IT&W) recognizes your rights as a client and has adopted the following:

- IT&W will provide considerate and respectful care in a safe and secure setting, free from all forms of abuse, neglect, or harassment. We will respect your rights without regard to race, gender, color, creed, age, religion, sexual orientation and national origin.
- You have the right to expect that the therapist will maintain professional and ethical boundaries by not entering into other personal, financial or professional relationships with the client.
- You will participate in the planning of your care, discharge plans, anticipated outcomes and treatment, and any discussions concerning ethical issues arising from your care. You may refuse any treatment unless mandated by law/court order. You will be informed of the expected consequences of your refusal.
- You have the right to end therapy at any time, for whatever reason and without any obligation, with the exception of fees for services already provided.
- IT&W reserves the right to discontinue treatment at any time including, but not limited to: a violation by the client regarding the treatment terms, a change or reevaluation by IT&W of the client's therapeutic needs, IT&W's ability to address those needs, or other circumstances that led IT&W to conclude in its sole and absolute discretion that the client's treatment needs would be better served at another treatment facility. Under such circumstances, IT&W will provide appropriate referral recommendations.
- The client will be informed verbally of the charges for treatment, which includes the charges for service that will not be covered by insurance and the charges that you as an individual may have to pay. Receipts/superbills can be given upon request. You are expected to pay your bills in a timely manner at the end of each session. For additional assistance with billing, please contact Echo Billing Solutions at 847-847-1792.

Additional Rights and Responsibilities:

Amendment: A client has the right to request that we amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by IT&W. You must make this request in writing and must provide a reason(s) to support your request for amendment. IT&W may deny your request under certain circumstances.

Appointments: IT&W provides outpatient psychotherapy services for clients of all ages. Our practitioners are fully licensed, have their own specialties and provide individual, couples, group, family counseling and case coordination. Therapy sessions are approximately 55 minutes long and are tailored to fit the client's specific goals and needs. Appointments are scheduled as needed.

Childcare: IT&W does not provide childcare and is not responsible for children and/or adolescents left unsupervised in the waiting room. If you must leave your child unattended in the waiting room during a session, it is your responsibility to provide appropriate supervision for your child. Children under the age of 12 should not be left alone. Minors must be picked up on time following their appointments.

Confidentiality: IT&W will protect your personal health information as confidential to the extent permitted by law. You will be asked to provide written permission for any release of information. Please refer to the Notice of Privacy Rights form for more details.

Confidential Communication: You have the right to request that our practice communicate with you about your treatment in a particular way. IT&W will respect all reasonable requests. Please communicate your preference to your therapist.

Contacting ITW: Therapists are often not immediately available by phone. While we are usually in the office Monday through Friday it is not our policy to answer the phone when we are in session with a client. When we are unavailable, our telephone is answered by voicemail or by our office administrator. We will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please provide us with your availability. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or call the nearest emergency room and speak with the mental health professional on call. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

File a Complaint: You have the right to file a complaint if you feel we have violated your rights. We will not retaliate against you for filing a complaint.

Illinois Firearm Concealed and Carry Act: Clients are not allowed to bring firearms and other weapons into our office. If this were to occur, the therapist has the authority to ask the client to reschedule and to leave the premises. The therapist is also permitted to contact authorities in order to protect their own safety and the safety of other individuals in the office/building.

Duty to Report: Therapists are required to notify the Illinois Department of Human Services of anyone who is determined to be a "clear and present danger" to themselves or others or determined to be developmentally and intellectually disabled.

Medical Records: You have the right to obtain a copy or a summary of your medical records. Please consult with your therapist for further instructions.

Obtain a list of those with whom we have shared information: You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.

Power of Attorney: If you have given someone a healthcare/medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ITW will ensure that this individual has this authority and can act for you before we take any action.

You are entitled to receive a paper copy of this Notice. If you'd like a copy, please ask your therapist.

Changes to the Terms of this Notice: IT&W can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website. This notice is effective (insert date) and applied to all individuals who procure services from a provider operating under ITW.

Please acknowledge that you:

- Have carefully reviewed all information in this document.
- Received a printed copy of this document if so requested.

I _____, hereby request psychological services from IT&W. I fully understand and accept IT&W's Rights and Responsibilities terms.

Client Signature Date:

(Client if 12 years or older)

Parent/Guardian Signature Date:

(Parent/Guardian if Client is Minor under 12 years of age/Personal Representative)

Witness Signature Date:

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SYMPTOMS CHECKLIST

Today's Date: _____

Client Name: _____

Person Completing Form (if different from Client): _____

Please indicate how often the following symptoms have occurred for the client in the last six months.

Area of Concern	Never/ Rarely	Sometimes	Often/More days than not	Daily	Area of Concern	Never/ Rarely	Sometimes	Often/More days than not	Daily
Feeling down and/or sad					Feeling anxious				
Feeling worthless					Feeling/experiencing panic				
Feeling hopeless					Fear of leaving home				
Loss of interest in activities/relationships					Struggles with social interactions				
Crying spells					Obsessive thoughts				
Feelings of guilt/shame					Compulsive behaviors				
Poor self-confidence					Easily startled				
Grief/Loss					Restlessness				
Thinking about death					Perfectionism				
Thinking about suicide					Trouble making decisions				
Sudden mood changes					Addictions: specify _____				
Absence from school/work					Tobacco use: cigarette/ e-cig/ vaping				
Difficulty concentrating					Alcohol use				
Easily distracted					Blackouts				
Impatience					Drug use: specify _____				
Irritability					Racing/intrusive thoughts				
Agitation					Hearing voices				
Feelings of jealousy					Hallucinations				
Financial problems					Homicidal thoughts				
Problems with family members					History of trauma				
Anger					Verbal/Emotional abuse (past/present)				
Aggression					Physical abuse (past/present)				
Stealing behaviors					Sexual abuse (past/present)				
Frequent lying					Self-injury				
Legal problems					Sexual dysfunction				
Low energy					Pornography				
Too much energy					Gastrointestinal issues				
Fatigue					Poor/no appetite				

Problems falling asleep					Weight loss/gain				
Problems staying asleep					Under eating/food restriction				
Sleeping too much/too little					Food and/or body preoccupation				
Nightmares					Overeating/Binging				
Chest pains					Vomiting				
Rapid heartbeat					Memory loss				
Shortness of breath					Feeling Tense				
Headaches					Chronic Illness				

Please let us know if there are other concerns you would like to discuss with your therapist:

_____

_____

_____

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Informed Consent and Authorization For Teletherapy

This informed consent contains important information focusing on doing psychotherapy using the phone or Internet. Please read this carefully and let your therapist know if you have any questions. When you sign this document, it will represent an agreement between Illuminate Therapy & Wellness (IT&W) and you, the Client.

Benefits and Risks Of Teletherapy

Teletherapy refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of teletherapy is that the client and clinician can engage in therapy services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is unable to access transportation to the session, has health concerns which prevent the level of safety needed to meet in-person, moves to a different location making access to the session problematic, encounters a pandemic and in-person sessions are restricted, and/or for any other reason in-person sessions cannot take place. Teletherapy can also be more convenient and take less time; it does, however, require technical competence with both clinician and client to be effective. Although teletherapy has its own benefits, it does differ from in-person psychotherapy. For example:

~ Risks to Confidentiality: Because teletherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear the session if it does not occur in a private place. Your therapist will take reasonable steps to ensure privacy on his/her end, but it is important that you find a private place for your session free from disruptions. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation. Lastly, it is essential to take steps to protect the privacy of the session on the device you will use.

~ Issues related to technology: Technology and/or privacy-related issues might impact teletherapy in several ways. For example, technology may stop working during a session, other individuals might be able to gain access to your private conversation, or unauthorized users could access stored data.

~ Crisis management and intervention: Therapists typically do not engage in teletherapy sessions with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in teletherapy, an emergency response plan will be developed to address potential crisis situations that may arise during the course of your teletherapy work.

Technology

You and your therapist will decide together which teletherapy service platform to use (audio or video) for sessions. You agree to use the video-conferencing platform selected by your therapist,

who will instruct you on how to use it. The platform may require you to have certain computer or cell phone systems to take part in our virtual sessions.

If the session is interrupted for any reason, such as the technological connection fails, your therapist will re-contact you via the teletherapy platform on which was agreed to conduct therapy. The need to switch platforms to the phone may occur should the Internet access be limited and prevent reconnecting via video.

Should there be a technological failure and the session cannot be resumed, your therapist will contact you to reschedule your session based on the amount of time disrupted.

Confidentiality

Your therapist has a legal and ethical responsibility to make his/her best efforts to protect all communications that are a part of your teletherapy. Your therapist will use a HIPAA compliant platform to help keep your information private, but there is a risk that others could compromise your electronic communications.

You understand and agree that there will be no recording of any of the online sessions by either party, without expressed consent. The extent and exceptions of confidentiality outlined, and agreed to, in IT&W's general Informed Consent still apply in teletherapy.

You understand and agree to the importance of using a secure Internet connection rather than public/free Wi-Fi.

You understand and agree that if you are a minor, you need the permission of your parent or legal guardian, as well as their contact information, to participate in teletherapy.

Emergencies

You understand and agree that the privacy laws that protect the confidentiality of your protected health information (PHI) also apply to teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; if mental/emotional health issues raised with relation to a legal proceeding.)

Assessing and evaluating threats and other emergencies can be more difficult when conducting teletherapy than traditional in-person therapy. To address some of these difficulties, an emergency plan will be created before engaging in teletherapy services. You will identify an emergency contact person who is near your location and who will be contacted in the event of a crisis or emergency to assist in addressing the safety needs of the situation.

You understand and agree that if you are having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy services are not appropriate and a higher level of care is required.

If the session is interrupted for any reason and you are having an emergency, do not call your therapist back; instead, call 911 or go to your nearest emergency room. You understand and agree that at this time my therapist will also call my emergency contact and/or appropriate authorities.

General Information

You understand and agree that it is important to be on time. If you need to cancel or change your teletherapy appointment, you will notify your therapist within the 24-hour cancellation requirement as stated and agreed-to in the Financial Policy and Agreement signed upon starting psychotherapy with IT&W. A late cancellation fee will be assessed per the policy agreed to if the session is not cancelled at least 24 hours in advance of the scheduled appointment.

You understand and agree that your therapist may determine that due to certain circumstances, teletherapy may no longer be appropriate and the return to in-person sessions is recommended. Your therapist and you will discuss options for engaging in in-person sessions or referrals to another professional who can provide appropriate level of care.

It is your responsibility to confirm with your insurance company regarding my teletherapy benefits. The same fee rates will apply for teletherapy as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance carrier does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session pursuant to said Financial Policy and Agreement.

Informed Consent

This agreement is intended to supplement the general Informed Consent already agreed-to at the outset of treatment and does not amend any of the terms of that agreement.

Your signature below indicates that you agree to these terms and conditions.

_____ _____

Client Signature/Signature of Legal Guardian or Parent if client is under 12 Date

_____ _____

Therapist Signature Date

In case of emergency, my emergency contact is:

_____ _____

Name Phone number

_____

Street Address City State