Client Information

Therapist Name: ______________________________

Your (Client) Name: _________________________________ Date of Birth: ___/___/______

Legal Guardian Name (if minor): _______________________ Legal Sex (*for insurance*): M F

Home Address: _______________________________ Marital Status: S M W D

City/State/Zip: _______________________________ May we send correspondence: Yes No

Email Address: _______________________________ May we send e-mail: Yes No

Home/Cell Phone: ____________________________ Permission to Contact: Yes No

May we leave a message on your voicemail? ☐ Yes ☐ No

May we send resource, billing, and scheduling information to you via e-mail/text? ☐ Yes ☐ No

My preferred method of communication is: ☐ Phone ☐ Text ☐ E-mail

** Please note: CG Therapies cannot guarantee confidentiality within texts or electronic communication. By selecting this method, you acknowledge this risk, consent to its use, and agree CG Therapies will not be held liable for unintentional breach of confidentiality. Additionally, you agree not to use electronic communication to seek counseling, advice, or when in a state of crisis.*

Are you a veteran? ☐ Yes ☐ No Branch: _________ Dates of Service ____________________

Emergency Contact: ______________________ Relationship: _________ Phone: ___________

Primary Doctor: _________________________________ Phone: ____________________

Medications & Dose: ____

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Notice of Practice Policies

CG Therapies LLC is a business facility where a number of mental health professionals practice. Each therapist is an independent practitioner. The name CG Therapies is for the purpose of shared office expenses. Your contract for services is with your therapist only and does not include a contract with any of the other therapists at this site. Please feel free to ask any questions about these policies.

Your First Visit:

- Please complete the intake paperwork prior to the start of your visit. The intake packet is available on our website: www.cgtherapies.com or there are copies available in the office area (allow 15 minutes).
- Your first visit will include a diagnostic assessment. At the end of your visit, your clinician will discuss a therapeutic plan and answer any questions.
- Therapy may include talking about emotionally provoking subjects and scenarios.
- Most sessions are 45-50 minutes.

Insurance:

- Please bring your insurance card and ID with you to your first visit and anytime there are changes to your plan/insurance
- CG Therapies is contracted with Blue Cross Blue Shield PPO, Blue Choice PPO & United Healthcare.
- Prior to your first visit, you will be provided an estimate of your cost for sessions. This is only an estimate and may be adjusted after cost has been confirmed through billing. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit.
- All **copays** are **due at each session**. We accept cash, check, or credit card; whatever your preference. If you are unable to pay your copay at session, you will be required to pay, prior to your next session. We reserve the right to suspend or terminate sessions due to unpaid copays.
- It is your responsibility to notify your therapist of any changes to your insurance policy.
- **If your claim is denied, full payment remains your sole responsibility.**
- **Session costs are as follows:**

CPT Code	Service Description	Rates
90791	Diagnostic Assessment	$160.00
90834	45 Minute Psychotherapy	$130.00
90837	60 Minutes Psychotherapy	$130.00
90853	60 Minute Group Psychotherapy	$60.00
N/A	Late Cancellation Fee	$100.00

______________________________________ ____________

Signature of Client/Legal Guardian Date

______________________________________ ____________

Signature of Witness Date

Appointments & Cancellations:

- If you need to cancel an appointment, please notify your therapist of leave a message with the office at least 24 hours in advance.
- Late cancellation (less than 24 hours before) *and/or* no-show appointments result in a **$100.00 fine**, which will be due, prior to your next session. Please note, insurance companies will **not** reimburse you for missed appointments.
- We reserve the right to request a different appointment time for you or terminate services if there are excessive missed appointments or unpaid bills.

Fees:

- We will provide billing services to insurances that we accept. We can provide an itemized bill for you to submit to an insurance that we are not associated with. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account.
- Clients paying on a cash basis, and not billing any insurance company, are expected to pay in full at **time of service** unless a payment plan has been previously arranged.
- Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.

Emergencies:

- CG Therapies provides services via appointment and is not prepared to respond to psychiatric emergencies. **If you are in crisis or feel that you may hurt yourself or others, please call 911 or visit your nearest emergency room department.**
- If you would like to speak to your therapist between sessions, but are not in crisis, please contact them by phone. Calls will be returned within 24 hours on weekdays. Weekend calls will be returned the next business day.

Your Responsibilities:

- Actively engage in and cooperate with the therapeutic process
- Let your therapist know if you have questions, are confused or uncomfortable with something
- Provide at least 24 hours' notice if you will not make an appointment
- Refrain from coming to sessions under the influence of mind altering drugs or alcohol
- Pay as agreed upon for services rendered.

Therapists' Responsibilities:

- Treat you with respect and maintain confidentiality according to signed agreements
- Practice with their level of competence, licensing guidelines, ethical standards outlined in state and national accrediting entities.

I have read, understand and agree to the above policies, guidelines, and rules. I have been offered a copy of these policies to take with me if desired. I hereby authorize CG Therapies and my therapist to release any information acquired in the course of my therapy to my insurance company. I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred.

____ ____________

Signature of Client/Legal Guardian Date

____ ____________

Signature of Witness Date

Notification to Primary Care Physician of Patient Receiving Mental Health Services

I understand that the State of Illinois advises that my primary care physician be notified that I am seeking assistance from CG Therapies. I am required to notify him or her that you are seeking or receiving mental health treatment unless you **waive** such notification.

Client Name: ______________________________ Date of Birth: ______________

Client Primary Care Physician: ______________________________ Phone Number: ______________

Address: ____

Client/Legal Guardian must initial preferred option and sign below:

___ I AGREE to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing **the Authorization to Release and Exchange Information** permitting you to communication with said physician.*****

___ I WAIVE NOTIFICATION of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to so notify him or her.

___ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a primary care physician that I am seeking or receiving mental health services.

______________________________________ ______________

Signature of Client/Legal Guardian Date

______________________________________ ______________

Signature of Witness Date

* If you selected "**I AGREE**," to notification, please complete the "**Authorization to Release and Exchange Information**" form with your primary care physician's contact information, so we may notify your PCP that you are receiving mental health treatment from us (therapist will mail letter of notification, after completion of this form).

Rights of Patient

Participation in treatment or any service at this practice does not diminish your rights. These rights include:

1. The right to impartial access to treatment regardless of race, religion, sex, ethnicity, age or handicap.
2. Any unusual, hazardous, or experimental services require your written and informed consent.
3. The right to be informed of the various steps and activities involved in receiving services.
4. All clients shall be free from abuse/neglect by and therapist within this practice.
5. You have the right to inspect and copy your record if you are age twelve or older.
6. The right to humane care and protection from harm, abuse, or neglect.
7. The right to make an informed decision whether to accept or refuse treatment.
8. The right to due process and contact and consult with legal counsel at my expense.
9. The right to select practitioners of my choice at my expense.
10. The right to confidentiality under federal and state laws relating to the receipt of services.
11. Except in emergencies, no services will be provided to you without your consent.
12. If your rights are restricted, the facility must notify:
    a. Your parent or guardian if you are under age eighteen
    b. You and the person of your choice
    c. The Guardians and Mental Health Advocacy Commission if you say you want the commission to be contacted. The Commission's address and telephone number are:

       160 North LaSalle, Suite S-500
       Chicago, IL 60601
       (312) 793-5900

    d. Equip for Equality if you say you want this organization to be contacted. Equip for Equality's address and telephone number are:

       160 North LaSalle, Suite S-500
       Chicago, IL 60601
       (312) 793-5900

13. You may not be denied services or have services suspended, terminated, or reduced in any way for exercising any of your rights as an individual.

I have read and understand these rights.

____ _______________
Signature of Client/Legal Guardian Date

____ _______________
Signature of Witness Date

Acknowledgement of Receipt of Notice of Privacy Practices

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of CG Therapies' "NOTICE OF PRIVACY PRACTICES."

As required by the Privacy Regulations, ______________________________________
from CG Therapies has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that CG Therapies has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all Protected Health Information (PHI) that it maintains.

On separate form(s), I am noting any additional persons to whom I wish my PHI to be communicated.

I agree that all my PHI may be communicated by letter, fax, or telephone and any or all of these forms of communication.

I understand that CG Therapies is not required to honor any changes to the "NOTICE OF PRIVACY PRACTICES."

____ ______________
Signature of Client/Legal Guardian Date

____ ______________
Signature of Witness Date

Credit Card Authorization

CG Therapies provides secured methods of accepting your payment at the time of service and for keeping your credit card on file.

I, (Card Holder or Authorized User) ________________________, authorize CG Therapies to maintain the credit card information and signature on file listed below, for charges, including copayments, deductibles, or coinsurance responsibilities, late cancellation fee charges as determined, and any outstanding balances for services unpaid.

I also attest that the information listed below is my personal information or I have obtained and have full authorization and permission to utilize it. If the card listed below is not my personal card, I accept all responsibility for payment and liability regarding any CG Therapies' charges that are disputed by the actual card holder.

I authorize CG Therapies to issue me receipt of payment via electronic mail. I understand that receipts from CG Therapies indicate that I am participating in mental health treatment services and I authorize the transmission of this information to the email address list below:

E-mail: ____

Client Name: ____

Card Holder Name: ____

Type of Credit Card: Mastercard Visa American Express Other: ______________

Credit Card #: ________________________________

Billing Address: _______________________________

Billing City, State: __________________ , _____ Billing Zip Code: ___________

Expiration Date: _______/_______ Security Code: ____________

____ _______________

Signature of Card Holder or Authorized User Date

____ _______________

Signature of Witness Date