NEW CLIENT INFORMATION

Client's Full Name:____

Date of Birth:____________________ Social Security #:____________________

Mailing Address:____

____

Home Phone:____________________ Cell:____________________ Email:__________________

Family Member Names	Dates of Birth (dd/mm/yy)	Relationship	Phone &/or Email if Different From Above

INSURANCE INFORMATION If not being utilized please check here ☐

Name of Insurance Plan:____

ID Number:____

Group Number:____

Policy Holder's Name:______________________ Person Responsible for Charges: __________________

Policy Holder's Date of Birth:________________ Policy Holder's Soc. Sec. #: ______________________

Policy Holder's Address and Phone if different from client's contact information: ____________________

____

Policy Holder's Employer:____

How were you referred to Edgewood Clinical Services, INC?:______________________________

Please list medical conditions that the identified client has:______________________________

Please list any prescription medications that the identified client takes: ______________________________

____

A Copy of Your Insurance Card Will Be Requested Upon Your First Visit

FOR OFFICE USE ONLY

Clinician Assigned:	
Date of First Session:	Scheduled Time:
FFS Rate if Insurance Not Being Utilized:	
Clinician Comments / Notes:	

INFORMED CONSENT

SERVICES

Edgewood Clinical Services, INC, provides counseling services to all age groups. We also provide psychological testing and case coordination for families who would like to utilize these services. All clinicians strive to be accessible by phone or email, but please be advised that we DO NOT offer 24 hour emergency crisis coverage. Please leave a message or send an email to a clinician to keep contact with them on an ongoing basis. If there is an emergency, please visit your nearest emergency room, or call 911.

CRISIS LINE PHONE NUMBERS

Crisis Line of Will County serves a geographical area which includes Will, Grundy, Southern DuPage, and portions of Southwestern Cook Counties. The numbers below (with the exception of the DuPage number) fit into this category.

Bolingbrook 630-759-4555

Frankfort 815-469-6166

Grundy County 815-942-6611

Joliet 815-722-3344

Mokena 708-479-1399

New Lenox 815-485-7366

Peotone 708-258-3333

Wilmington 815-476-6969

DuPage County Crisis Line…..630-627-1700

FEES

The fees for service will be:
$175.00 per 50 minute session provided by a Clinical Psychologist
$150.00 per 50 minute session provided by a Masters level Clinician
$50 per 50 minute session for groups

Initial assessments are $190 for Clinical Psychologists and $175 for a Masters level Clinician.
Sessions which are 60-90 minutes are $175.

Appointments will be scheduled at a time mutually acceptable to both the client and the therapist. 24-hour advance notice of cancellation is required, except in cases of extreme emergency.

Appointments missed or canceled with less than 24 hours notice will result in a charge of $35.00.

If a check is returned for insufficient funds, the client is responsible for any bank fees assessed, and an alternative method of payment will be required.

All co-payments are due at the time of service.

________ Initials

CONFIDENTIALITY

In order to provide effective treatment for the client's needs, the therapist will ask many personal questions. You can be assured that all personal client information is kept STRICTLY CONFIDENTIAL. Absolutely NO INFORMATION about your case will be released to anyone without your written authorization and consent.

Licensed Psychologists, Clinical Social Workers, and Counselors in the state of Illinois are required by law to report any suspected child abuse or neglect. They are also required to make a report if a client is a lethal danger to themselves or others.

As a client, I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that all communication with other providers or individuals can be made by Edgewood Clinical Services, INC, only by my signed or verbal consent.

________ Initials

INSURANCE

As a Client, I understand that Edgewood Clinical Services, INC, will verify my insurance benefits and coverage. I understand that I am solely responsible for out of pocket costs that may be incurred, and the benefit information that Edgewood Clinical Services, INC, may relay to me from my provider is not a guarantee of coverage or benefits.

As a Client, I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits to the supplier of services provided to myself, child, or family.

________ Initials

CONSENT FOR TREATMENT

As a Client, I consent to the evaluation and treatment process with Edgewood Clinical Services, and I understand that this process may include myself, my spouse, my children, and/or other family members. I understand that I have the right to withdraw from treatment at any time.

In general, your number of visits will depend on the type(s) of issues that exist, the recommendations made, and the effort that the client(s) put forth into following through with suggested recommendations.

________ Initials

Client Signature (12 & over):__________________________________ Date:________________

Parent/Guardian Signature:____________________________________ Date:________________

FINANCIAL STATEMENT

Edgewood Clinical Services, Inc. is committed to providing the highest quality of counseling and psychological services to all of its clients. In order to do so, Edgewood Clinical Services, Inc. and its clients must understand the benefits provided to the client through their insurance provider, or otherwise clearly outline a fee structure for services that will be paid in full by the client directly.

Many insurance plans have deductibles, co-insurance, and co-pay amounts that are the client's responsibility; deductibles must be met before insurance will begin to cover the cost of counseling. These deductibles apply to ALL medical providers; they are not isolated to mental health.

Edgewood Clinical Services, Inc. wishes to ensure that all families can have access to services. If there are circumstances that prevent a client from meeting the financial obligations of obtaining services, they should contact Adam Russo, LCSW, Executive Director, to explore payment options. Edgewood Clinical Services, Inc. does require prompt payment for services provided, and all accounts that have not received a payment towards the account balance within 90 days of the last date of service may be forwarded to collections. Additional fees will apply to the total balance if this occurs. Edgewood Clinical Services, Inc. is open to creating payment plans or exploring other alternatives should the need arise. Again, please speak with Adam Russo, LCSW, if there are concerns.

My signature below reflects my understanding of the financial policy at Edgewood Clinical Services, Inc.

Client/Parent/Guardian Signature____

(date)

CREDIT CARDS

All clients have the opportunity to keep a credit card number on file for convenient payment. If you decline to keep your information on file, please read and initial the statement below.

Declining to Have a Credit Card on File

________ Initials

I have read and understand the financial policies of Edgewood Clinical Services, Incå. I understand that I am responsible for timely payment of all amounts due, and my account will be sent to a collections agency if no payments are made within 90 days towards dates services are rendered. I understand that I can speak with Adam Russo, LCSW, Executive Director, to set up a payment plan should the need arise.

Credit Card Information

If you wish to keep your information on file, please be sure to complete all sections:

1) Card Holder's Name______________________________ 2) Expiration Date_________

3) Visa/Mastercard (circle one, flex spending accepted) 4) Security Code__________

5) Credit Card Number____

6) Card Holder's Signature____
(date)

7) Best Phone number to reach Card Holder______________________________________

8) Card Holder's email____

Please read each section below and indicate the manner in which you would like your card on file to be charged. **By signing below, I am authorizing Edgewood Clinical Services, Inc. to charge my card according to how I complete the information below.

____ Select this option:
I authorize my card to be charged the co-pay amount or the full fee (if not utilizing health insurance) at the time of each service.

Signature____

____ Select this option:
I authorize my card to be charged one time per month for all services rendered that month. This is to include all co-pays or full fees (if not utilizing health insurance) incurred during the month.

Signature____
(options continue on next page)

_____ Select this option:
I authorize my card to be charged after Edgewood Clinical Services receives Explanation of Benefit information from my insurance company. I understand that the entire client portion remaining will be charged.

Signature____

____ Select this option:
I authorize my card to be charged only after Edgewood Clinical Services contacts me to verify the amount owed and the amount that will be charged on my card.

Signature____

All credit card charges will generate a receipt that will be mailed to your address. By signing above, please understand that your credit card will be charged according to the preferences that you have indicated. If you would like to change this option, Edgewood Clinical Services must receive a written request to do so. Please contact us if you have further questions or concerns.

GROUP INFORMATION

Edgewood Clinical Services, LLC, is committed to providing quality group counseling to kids of all ages. Because the kids in our groups will vary in age, symptom presentation, developmental skills, etc., the groups will be tailored to ensure that all members of the group can receive the maximum benefit by participating and engaging in the conversations and activities that the group leaders provide.

The activities that group leaders provide will vary, depending on the group. Some groups may involve art, games, skill building, role playing, or other things that will focus on a specific area of development for the members of the group. The reason why these different modalities are used is because oftentimes, kids resist having a conversation or dialogue about certain topics. Having groups centered on an activity allows kids to be less defensive about sensitive topics and allows them to more easily express their feelings and thoughts. It also provides more of a 'real-world' setting to address issues such as social and anger management skill development.

Because our goal is to have children express their thoughts and feelings as well as learn new skills, the tone of the groups will vary. Groups may sound loud and 'out of control', extremely quiet, and everything in between. This is a natural part of the group process, and the tone doesn't mean that one type of group is better than another for the participants. We continue to want the members of the groups to be able to be kids, and not expect them to participate in groups the same way that we would expect an adult to engage.

We thank you for enrolling your child in our group program, and if you have any questions or concerns please consult the clinician leading your group, or contact Adam Russo, Executive Director of Edgewood.

MEMBER CONTACT OUTSIDE OF THE GROUP

Edgewood Clinical Services, LLC, is aware that one of the reasons why parents decide to enroll their child in a group is so they can have the opportunity to socialize with other children in a structured setting. During this time, children may develop friends in the group, and may want to see them outside of the group as well.

Edgewood Clinical Services, LLC, discourages this from happening. As a parent, if you decide to have your child play with another member of the group outside of the group, we need to ensure that you are informed. Please keep in mind the following if you are setting up a time for children to play together outside of group:

1) Ensure that all children involved will be supervised by a parent or guardian

2) Because of HIPPA, Edgewood Clinical Services, LLC, cannot provide a parent or guardian information about another member of group

3) If children do play together, encourage them to continue to be respectful of other members of the group when they return to the group, even though they do not want to socialize with them outside of it.

All children have different struggles, and because Edgewood Clinical Services, LLC, cannot disclose what potential unsafe or problematic behaviors may be displayed by children to parents of other children, parents will decide to have children play together AT THEIR OWN RISK. Edgewood Clinical Services, LLC, does not sponsor any activities that take place with group members outside of the groups provided and lead by Clinicians contracted with Edgewood Clinical Services.

I have read the above and understand that if I decide to allow my child to play with another child outside of the group setting provided by Edgewood Clinical Services, LLC, I am fully responsible for the care and supervision of the children, and will not hold Edgewood Clinical Services, LLC, or its Clinicians liable for any actions displayed by the children.

____   ________________

Signature (Parent or Guardian)   Date

____

Print Child's Name

*This form is not required. Please complete if there is anyone else you would like your clinician to be able to exchange information with such as your Primary Care Physician, Pediatrician, School Social Worker, Spouse or other Treatment Provider.

CONSENT FOR RELEASE OF INFORMATION

I, ____________________________________, authorize Edgewood Clinical Services:

☐ to give information to

☐ to receive information from

Name:____

Organization:____

Address:____

Phone:__________________________ Email:_______________________________

Regarding (Client Name):____

This information to be exchanged from ___________________ to __________________.

The Purpose For This Release of Information is:

☐ Continuity of Care / Treatment Planning

☐ Documentation/Discharge Paperwork Request

☐ Information Sharing

☐ Notice of required counseling/assessment

☐ Academic Support Needs

☐ Connection with Support Services

____

Client Signature: ______________________________________ Date: ___________________

Parent/guardian Signature: ______________________________ Date: ___________________

GENERAl INFORMATION - GROUPS

FOR YOUR INFORMATION

At the time of your initial visit, you will be requested to complete routine forms. These forms consist of a client information form, a consent to treatment form, and a release of information form. The release of information will be discussed prior to its completion.

In general, the number of visits you will require will depend on the type(s) of issues that exist, the recommendations made, and the effort that the client(s) put forth into following through with suggested recommendations.

APPOINTMENTS

Appointments will be scheduled at a time mutually acceptable to both the client and the therapist. 24-hour advance notice of cancellation is required, except in cases of extreme emergency.

Appointments missed or canceled with less than 24 hours notice will result in a charge of $15.00. This is because kids like to have the same kids with them in group each week, and lack of consistency with group participants does inhibit the group process.

FEES

The fee for service will be $50.00 per 50 minute session. A sliding fee scale is available.

Payment for all services is required at time of service.

CONFIDENTIALITY

In order to provide effective treatment for the client's needs, the therapist will ask many personal questions. You can be assured that all personal client information is kept STRICTLY CONFIDENTIAL. Absolutely NO INFORMATION about your case will be released to anyone without your written authorization and consent.

Licensed clinical social workers in the state of Illinois are required by law to report any suspected child abuse or neglect. They are also required to make a report if a client is a lethal danger to themselves or others.

I HAVE READ THIS PATIENT INFORMATION SHEET, I UNDERSTAND THE REQUIREMENTS OF THIS OFFICE, AND AGREE TO THE TERMS THEREIN.

Client Signature:___________________________________ Date:________________

Therapist:____ Date:________________