Internal Strength Counseling, LLC
787 Sunset BLVD, Suite 100, O'Fallon, IL 62269
Office Phone: 618-671-0817
Office Fax: 618-726-2035
Email: kellisilhavylcsw@gmail.com

New Client Packet

Welcome to Internal Strength Counseling, LLC. Full completion of this packet will enable us to provide you with the best possible service.

Please bring the following to your first appointment.

- Insurance Card
- Driver's License or Photo ID
- Copay or other payment.

Please note the following:

Client Registration (next page) must be filled out completely. The date of birth and social security number of the insurance policy holder is required to submit insurance claims. If you do not have this information, we cannot bill your insurance. You would then be held responsible for charges that your insurance would otherwise cover.

Completion of this packet in its entirety is necessary.

Please Review Check that each page has been signed and initialed.

Thank you for your cooperation and patience in filling out these forms to help us better understand your needs and bill your insurance correctly.
I look forward to working with you.

Initials _____

CLIENT REGISTRATION

The information below is pertaining to the Parent/Guardian of the minor being seen.

Today's Date: _____

Your Name: _____

Relationship to minor: _____

Contact Information

Home Address: _____

_____

_____

*Authorization for Internal Strength Counseling, LLC to send mail to the address listed above: Yes or No (please Circle One)

Phone(s): _____

*Authorization for Internal Strength Counseling, LLC to leave voice messages on Phone(s) listed above: Yes or No (please Circle One).

Email Address: _____

*Authorization for Internal Strength Counseling, LLC to email the address listed above: Yes or No (please Circle One).

Minor Demographics:

Sex: M/F _____

Name: _____

School/Grade: _____

Physician: _____

Referred By: _____

Emergency Contact:

Name/Phone: _____

Initials _____

Insured/Responsible Party Information

All Items in this section must be completed to bill your insurance.

If using Private Pay Please Circle N/A and skip to the Next Page

Policy Holder Information:

Policy Holder's Full Name: _____

Policy Holder's Phone #: _____

Policy Holder's DOB: _____

Policy Holder's SS #: _____

Relationship to the Client: _____

Policy Holder's Address: _____

Policy Holder's Employer: _____

Employer's Address: _____

_____

Employer's Phone #: _____

Insurance Provider's Information:

Primary Insurance Company: _____

Insurance I.D. #: _____

Insurance Group #: _____

Mental/Behavioral Health Phone: _____

(Located on Back of Ins. Card)

Secondary Insurance Company: _____

Insurance I.D. #: _____

Insurance Group #: _____

Mental/Behavioral Health Phone: _____

(Located on Back of Ins. Card)

Initials _____

Appointment Information

Today's initial appointment will take approximately 45-60 minutes. Starting counseling is a major decision and you may have many questions. This document is intended to inform you of what to expect, our policies, State and Federal Laws, and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.

OFFICE HOURS Office hours are Monday, Wednesday, Thursday (8-5). You may reach the office by phone at (618) 671-0817 to schedule an appointment. If unavailable, you may leave a message on our office voice mail box and a staff member will return your call as soon as possible during normal business hours. Do not leave messages if you have a psychiatric emergency; please dial 911, or go to the Emergency Room.

COMMUNICATION
It is our normal practice to communicate with you at your home address and daytime phone number that you gave us when you scheduled your appointment about health matters, such as appointment reminders, etc. You have the right to request that our office communicate with you in a different way. Please DO NOT provide phone numbers if you do not wish for us to leave messages. If a phone number is provided as a form of contact, the front office will leave a message at that number.

FINANCIAL/INSURANCE As a courtesy, we will bill your insurance company if you wish. However, you are responsible to be aware of your coverage and benefits. You will be held financially responsible for any remaining balance or sessions that are not covered by insurance. All payments and/or co-payments are due at the time of each appointment. If you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If we receive more than one returned check from an individual we may refuse future payment by check.

SICK/ NO SHOW AND LATE CANCELLATION POLICY
Please contact our office within 24 hours if you are not able to make your appointment. If you do not show for a scheduled appointment or cancel with less than 24 business hours notice, a NO SHOW/LATE CANCELLATION FEE of $50.00 may be charged for the cost of the missed appointment. This cost is not covered by insurance and is your responsibility and must be paid in full before your next appointment. It is at the therapist's discretion to bill for No-Show/ Late-Cancel as well as to terminate treatment if 3 appointments have been missed without appropriate cancellation.

However, we understand that life throws us curve balls and not all appointments can be canceled within 24 hours. We ask that you do your best to respect our time and give us as much notice as you can. If you are sick, PLEASE CALL US TO RESCHEDULE. IF YOU SHOW UP NOTICEABLY SICK (FEVER/VOMITTING), YOUR THERAPIST HAS THE RIGHT TO RESCHEDULE. Your therapist will also reschedule in the event she is sick with the goal to keep you healthy.

Minors and Parents

Therapy is most effective when a trusting relationship exists between the therapist and the client. Privacy is especially important in securing and maintaining trust. While privacy in psychotherapy is very important, parental involvement is also essential to successful treatment. Therefore, it is our policy that any client under the age of 18 and his/her parents understand that only general information will be shared with parents including the child's diagnosis, progress in treatment, and the child's attendance at scheduled sessions. Parents will be informed if a disclosure is required by law. All other information the child provides will remain confidential unless authorized to be released by the child. By signing this agreement, you will be protecting your child's privacy by waiving your right of access to your child's treatment records. Please be aware that your child is unlikely to utilize therapy to discuss his/her decisions in areas that will be reported to you. If we ever believe that your child is at serious risk of being harmed or of harming him/herself or another, we will inform you.

You agree that you will treat anything that is said in session with me as confidential. Neither parent will attempt to gain advantage in any legal proceeding between the two of you through your therapist's involvement with your child. In particular, you agree to instruct attorneys not to subpoena your therapist or the client's records to refer in any court filing to anything that I have said or done. You additionally agree not to ask your therapist not to testify in court.

Disclosure Regarding Divorce and Custody Litigation

If you are involved in divorce or custody litigation, my role as a therapist is not to make recommendations to the court concerning custody or parenting issues. By signing this Disclosure statement, YOU AGREE NOT TO SUBPEONA me to court for testimony or for disclosure of treatment information in such litigation; and YOU AGREE NOT TO REQUEST that I write any reports to the court or to your attorney, making recommendations regarding custody. The court can appoint professionals, who have no prior relationship with family members to conduct an investigation or evaluation and to make recommendations to the court concerning parental responsibilities or parenting time in the best interests of the family's children. If this is your reason for seeking counseling, please be honest and we will provide you with a referral. By signing this you understand, that I DO NOT DO COURT RELATED COUNSELING. If I do become involved in a legal matter out of requirement, the starting fee is $5,000 payable in advance. If you provide a release for you or your child's records to an attorney, this is considered involving me in your court/legal matter.

Signature is required: _____ DATE:_____

Parent Understanding and Consent
(For Children 12 and under seeking therapy)

Children entering therapy age 12 and under must have consent from their legal guardian(s). If there is a joint custody agreement, both parents must be aware of treatment and provide consent to Internal Strength Counseling, LLC for their child to be receiving counseling services. A copy of the custody agreement must be provided to therapist to have on file.

CHILD'S NAME:_____ DOB: ___/___/___

PARENTS: (Name all parents/step-parents/legal guardians. CUSTODIAL parent(s) must sign form)

Mother:

Name: _____

Address:_____,_____,_____,_____
(City) (State) (Zip)
DOB:___/___/___ Age:____ Home or Cell Phone:_____

Occupation:_____ Work Phone:_____

Single Married Partnership Separated Divorced (Please Circle One)

Step-Mother:

Name: _____

Address:_____,_____,_____,_____
(City) (State) (Zip)
DOB:___/___/___ Age:____ Home or Cell Phone:_____

Occupation:_____ Work Phone:_____

Father:

Name: _____

Address:_____,_____,_____,_____
(City) (State) (Zip)
DOB:___/___/___ Age:____ Home or Cell Phone:_____

Occupation:_____ Work Phone:_____

Single Married Partnership Separated Divorced (Please Circle One)

Step-Father:

Name: _____

Address:_____,_____,_____,_____
(City) (State) (Zip)

DOB:___/___/___ Age:____ Home or Cell Phone:_____

Occupation:_____ Work Phone:_____

Legal Guardian

Name: _____

Address:_____,_____,_____,_____
(City) (State) (Zip)

DOB:___/___/___ Age:____ Home or Cell Phone:_____

Occupation:_____ Work Phone:_____

I, (*Print Name*)_____ attest that I am the custodial parent of
above named minor, and I authorize child to participate in psychotherapy with this office. I agree and understand that while insurance may be billed for psychotherapy services, I am legally responsible for any and all charges incurred in providing this and/or other services by this office. Copies of documentation of legal custody of child, and any other legal issues pertaining to child must be provided on, or before date of first visit. Copies of these documents will be kept in child's record.

_____ _____
CUSTODIAL PARENT (Mother/Father/Guardian - Circle One) DATE

UNDERSTANDING PSYCHOTHERAPY INFORMED CONSENT

It is important for you to understand what counseling is about and what you may expect during therapy. Please read this material carefully and ask your therapist to explain anything that is unclear to you. What are Counseling and Psychotherapy?

"Counseling" and "Psychotherapy", or simply "therapy", are words for the same process which is: using proven methods to assist people in changing how they think, feel and behave. Legitimate therapy is practiced by licensed professionals in their field of expertise (i.e. social work, counseling, psychiatry). At Internal Strength Counseling, LLC you will meet with a licensed clinical social worker.

How does therapy work?

Therapy will involve several steps. Therapy sessions are usually 45 to50 minutes in length, and are typically held one time per week to start.

First, your counselor will listen to the concerns that you brought to counseling. He/she will get to know you and how you view your life and yourself. You will probably understand your situation better as you and your counselor talk. After you and your counselor explore your concerns, you will choose specific goals and objectives for therapy. Next, you and your counselor will work together to develop a plan for meeting those goals.

You and your counselor will define and work toward accomplishing your goals using research-proven methods. These methods include, for example, accessing your inner strengths and resources, changing thoughts that affect how you feel and what you do, or homework assignments in which you try on new behaviors to see how they fit. You and your counselor may decide to involve other family members in your session. Please know that any work in the sessions will occur only with your permission. It is very important to your counselor to see that your limits are respected. Your specific needs and concerns will determine what is done.

Your counselor will frequently take time to examine your progress toward your goals to make sure you both are on the right track. You and your counselor will decide together when your therapeutic goals are met and when to move toward completing therapy. Your therapy may be terminated if you fail to maintain regular attendance or if your therapist feels you are not making progress. You will be notified in advance of any possible termination of services.

CONFIDENTIALITY AND EMERGENCY SITUATIONS:

If an emergency situation for which the client or their guardian feels immediate attention is necessary, <u>the client or guardian understands that they are to contact emergency services (911), or proceed to the nearest Emergency Room for assistance.</u> Your therapist is not on-call outside of their office hours. However, your therapist will follow up those emergency services with standard counseling and support to the client or the client's family.

Your verbal communication and clinical records are strictly confidential except for situations covered in the Notice of Privacy Practices. Please note that confidentiality cannot be guaranteed if you use electronic communications with practitioners or office staff. This includes e-mail, instant messaging, social media and text.

Therapists are required to keep secret the identity of their clients. **Consequently, I will not acknowledge you in a public setting to ensure your confidentiality is protected. I also will not accept any social media invitations/friend requests.** My duty as a therapist is to care for my clients in a professional role of therapist. In general, communications between a client and a therapist as well as records pertaining to those communications are confidential and may not be

released without written authorization by the client or the client's legal guardian. However there are a few exceptions:

- Administrative Personnel: You should be aware that I employ administrative personnel. In most cases, I need to share protected information with these persons for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. Office staff members are bound by the same rules of confidentiality. Office staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice.
- Consultation: I regularly consult with other professionals about therapy cases in order to provide my clients with quality care. During a consultation, every effort is made to avoid revealing the identity of my clients. The consultant is also legally bound to keep information confidential.
- Other Privacy practice restrictions: Please read/ sign the notice of privacy practices attached to this document for an understanding of when it is required by law for me to disclose information.

If you have any questions, feel free to discuss the limitations of confidentiality with your therapist.

Initials _____

You have the right:

To be treated in a humane and dignified way. ·
To be informed of your treatment options, risks, and benefits. ·
To take an active role in treatment planning. ·
To have questions answered fully. ·
To have confidentiality and privacy within legal/ethical guidelines. ·
To facilitated review of your clinical information.

You have the responsibility:

To be honest in providing information.
To keep your appointments, to be on time, and to give a 24 hour notice if you should need to cancel your appointment.
To be free of alcohol/drugs during your therapy session.
To respect the therapist and facility.
To respect the privacy and rights of others.
To know your insurance requirements, deductibles, and co-pays.
To pay your co-pay, deductible, or full charge at the beginning of each appointment.

_____ _____

Client Signature (12 and over) Date

_____ _____

Guardian Signature Date

COORDINATION OF TREAMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared, however we do need your physicians name and demographic information for insurance billing.

____You may inform my physician(s) ____I decline to inform my physician

Physician's Name: _____

Physician's Phone #: _____

Clinic Name: _____

Physician's Address: _____

_____ _____

Client Signature (12 and over) (Communication with physician) Date

_____ _____

Guardian Signature (Communication with physician) Date

NOTICE OF PRIVACY PRACTICES AND CLIENT RIGHTS: I/We have reviewed and received a copy of the Notice of Privacy Practices, if requested. Signing this acknowledgement does not mean you have agreed to any uses or disclosures of your protected health information outside the purposes outlined in the Notice of Privacy Practices.

_____ _____

Client Signature (12 and over) (Notice of Privacy Practices) Date

_____ _____

Guardian Signature (Notice of Privacy Practices) Date

AUTHORIZATION

I authorize treatment deemed necessary by Internal Strength Counseling, LLC. I authorize Internal Strength Counseling, LLC to release to my health plan any and all information which is deemed necessary regarding my care and treatment to ensure prompt payment of all charges for services provided. I hereby assign the payment for all insurance benefits to Kelli Silhavy, LCSW, MSW for any and all charges incurred in connection with services provided to me. I also consent to a copy of this authorization and assignment being used in place of the original.

I understand fully that I remain responsible to pay Internal Strength Counseling, LLC for all charges not paid by either my insurance companies and/or employer. Payment shall be due at the time of the appointment or within thirty days of receipt of a statement. I understand and authorize that if payment is not received by Internal Strength Counseling, LLC within this time Frame, my credit card on File will be charged.

_____ _____

Client Signature (12 and over) Date

_____ _____

Guardian Signature Date

Contractual Agreement between Client(s) and Internal Strength Counseling, LLC
Signature on File

My Signature(s) hereon authorizes Internal Strength Counseling, LLC to submit insurance claims to applicable insurance/EAP companies on my behalf and authorizes the release of any information necessary to process this claim to include release of medical records and payment authorization applicable to any current future treatment.

_____ _____

Client Signature Date

_____ _____

Guardian Signature Date

Please be aware that outpatient therapy may not be the appropriate level of care for you at this time based on the severity of what you are struggling with. We ask that you be completely honest with us about your symptoms so that we can either offer the best care or refer to a more appropriate level of care.

<u>Presenting Problem and Treatment History</u>